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Rules of Governmental Agencies

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111 East Monroe Street
Springfield, IL 62756
(217) 782-7017
http://www.sos.state.il.us

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PROPOSED RULES

Editor's Note: The Cumulative Index and Sections Affected Index will be printed on a quarterly basis. The printing schedule for the quarterly and annual indexes are as follows:

April 19, 1996 - Issue 16: Through	March 31, 1996
July 19, 1996 - Issue 29: Through	June 30, 1996
October 18, 1996 - Issue 42: Through	September 30, 1996
January 17, 1997 - Issue 3: Through	December 31, 1996 (Annual)

INTRODUCTION

The *Illinois Register* is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category. The Register also contains a Cumulative Index listing alphabetically by agency the Parts (sets of rules) on which rulemaking activity has occurred in the current Register volume year and a Sections Affected Index listing by Title each Section (including supplementary material) of a Part on which rulemaking activity has occurred in the current volume year. Both indices are action coded and are designed to aid the public in monitoring rules.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or peremptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State statute; and activities (meeting agendas, Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State agencies; is also published in the Register.

The Register is a weekly update to the *Illinois Administrative Code* (a compilation of the rules adopted by State agencies). The most recent edition of the Code along with the Register comprise the most current accounting of State agencies' rules.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1 et seq.].

REGISTER PUBLICATION SCHEDULE 1996

Material Rec'd after 12:00 p.m. on:	And before 12:00 p.m. on:	Will be in Issue #:	Published on:
Dec. 19, 1995	Dec. 26, 1995	1	Jan. 5, 1996
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Please note: When the Register deadline falls on a State holiday, the deadline becomes 4:30 p.m. on Monday *(the day before).*

Printed by authority of the State of Illinois
August 1996 – 710 – GA-168

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Local Tourism and Convention Bureau Program

2) Code Citation: 14 Ill. Adm. Code 550

3) Section Numbers: Proposed Action:
550.10 Amendment
550.50 Amendment

4) Statutory Authority: Implementing Section 46.8a of the Civil Administrative Code of Illinois [7 ILCS 805 46.8a and Section 9.25 of the State Finance Act [30 ILCS 105 9.25] and authorized by Section 46.20 of the Civil Administrative Code of Illinois [20 ILCS 805 46.20].

5) A Complete Description of the Subjects and Issues Involved: Section 40.1a is being amended to remove the requirement of 10 days prior submission for implementation of proposed projects. Section 50.10 is being amended to delete "Performance Measurements Summaries" form information required to be submitted with the Quarterly Reports.

6) Will this rulemaking replace any emergency rulemaking currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending in this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805 3(b)].

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after this edition of the *Illinois Register* to the following:

Ms. Pamela D. Pennebaker, Grants Manager
Illinois Bureau of Tourism
Department of Commerce and Community Affairs
620 East Adams Street
Springfield, Illinois 62701
217 785-6998
T.D.D.: 217 785-6998

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Small travel and industry related businesses will be enhanced by the Bureaus increased ability to promote their respective service areas.

B) Reporting, bookkeeping or other procedures required for compliance: Knowledge of accounting as required by grantee staff and, in the future, grantee staff will need the ability to report financial expenditure information via an electronic data processing system.

C) Types of professional skills necessary for compliance: Applicants will need a basic understanding of the application and monitoring processes. Grantee staff must have financial management skills in order to implement their grants.

13) Regulatory Agenda on which this rulemaking was summarized: January 1996

The full text of the Proposed Amendment begins on the next page:

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DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF PROPOSED AMENDMENT

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

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TITLE 14: COMMERCE
SUBTITLE C: ECONOMIC DEVELOPMENT
CHAPTER I: DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

PART 550
LOCAL TOURISM AND CONVENTION BUREAU PROGRAM

Section
550.10 Purpose
550.20 Definitions
550.30 Allocation of Appropriations to Grantees
550.35 Eligible Applicants
550.40 Program Requirements
550.50 Administrative Requirements
550.60 Application Process

AUTHORITY: Implementing Section 46.6a of the Civil Administrative Code of Illinois [20 ILCS 605/46.6a] and Section 8.25 of the State Finance Act [30 ILCS 105/8.25] and authorized by Section 46.21 of the Civil Administrative Code of Illinois [20 ILCS 605/46.21].

SOURCE: Adopted at 9 Ill. Reg. 4778, effective April 4, 1985; amended at 12 Ill. Reg. 2206, effective January 19, 1988; amended at 14 Ill. Reg. 5091, effective March 30, 1990; emergency amendment at 14 Ill. Reg. 5565, effective March 28, 1990, for a maximum of 150 days; emergency expired August 25, 1990; amended at 14 Ill. Reg. 18746, effective November 9, 1990; amended at 15 Ill. Reg. 1798, effective January 29, 1991; emergency amendment at 15 Ill. Reg. 10498, effective June 26, 1991, for a maximum of 150 days; emergency expired November 23, 1991; amended at 16 Ill. Reg. 3464, effective February 20, 1992; amended at 16 Ill. Reg. 14628, effective September 14, 1992; amended at 19 Ill. Reg. 1308, effective February 7, 1995; amended at 20 Ill. Reg. __________, effective ____________________.

Section 550.40 Program Requirements

a) Project Approval Criteria
   1) All projects expenditures utilizing LTCB grant funds shall be submitted to the Department for review and approval prior to project initiation.
   2) When the total cost for printed projects, purchase of premium items, or other projects deemed appropriate by the Department exceeds $5,000, a minimum of two bids using identical specifications shall accompany the project request.
   3) All projects funded through the grant program shall incorporate the current Department logo, as approved by the Department, which identifies the project as being developed in cooperation with the DCCA/Bureau of Tourism. A bureau which fails to include the Department identification shall reimburse the Department for

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State funds received in support of the project.
   4) The date and quantity printed (e.g., 7/91-50 m) shall appear on brochures.
   5) The bureau shall bear sole responsibility for accuracy of information contained within material produced with grant funds.
   6) All printed projects that are funded through LTCB grant funds shall be available on a gratis basis - free of charge - to the public.
   7) ~~Bureaus shall allow a minimum of 15 calendar days prior to initiation of a project for review and notification. The Department shall waive the 15 calendar days prior notice requirement when unforeseen opportunities for promotional projects arise which require an immediate review and response by the Department.~~ The project review request shall include the following information:
      A) grant number;
      B) project number;
      C) bureau name;
      D) project title;
      E) description;
      F) vendor name(s), description of services to be provided by vendor(s), and itemized costs;
      G) estimated project cost, amount of LTCB funds, amount of local funds, total estimated project cost;
      ~~H) project requests which require waivers of the 15 working days prior notice shall include documentation to substantiate that such promotional projects require immediate review/approval by the Department to ensure the opportunities are not lost;~~
      H~~I~~) check-off list for the following:
         i) evidence of bid solicitation when the total cost for printed projects, purchase of premium items, or other projects deemed appropriate by the Department exceeds $5,000;
         ii) mock-ups or samples of projects;
         iii) Department logo;
         iv) whether project is outlined in LTCB "Line Item Budget"; and
         v) review, approval, and sign-off.
   8) If the project review request form is complete and is accompanied by the required supporting documentation, including current Department logo, and is determined to be an eligible project, the project will be approved, subject to fund availability.
   9) Project costs shall be deducted from future grant payments when bureaus fail three times to submit project review requests for prior approval during the program year. ~~Projects granted waivers of the 15 working days prior notice shall not be counted under this subsection.~~

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10) Within [illegible] days after completion of a project, up to [illegible]% of the brochures printed may be required to be sent to the Department's tourist information centers. The Department reserves the right to request up to [illegible]% of all other items produced with grant funds.
11) Project activities funded under this Part shall not duplicate any project funded by the Department.
12) Salaries and related payroll expenses for the program year shall not exceed half of the total grant funds.
    A) [illegible]% sales promotion staff persons salary may be applied toward half of the total grant.
    B) [illegible]% Executive Director's salary may be applied toward half of the total grant.
13) Bureaus are prohibited from hiring any immediate family member of staff or immediate family member of a board member who is involved in the hiring decision of staff, if grant or match funds are utilized. Immediate family members shall include a spouse, mother, father, daughter, and son.

b) Promotional Projects
   1) Examples of eligible promotional projects include, but are not limited to:
      A) Brochures;
      B) Travel trade show booth space rental, purchase of booth, registration fees, and/or travel expenses (transportation, lodging, per diem at State rate, for a maximum of [illegible] staff. Justification shall accompany requests for additional people to attend;
      C) Sponsorship of familiarization tours;
      D) Placement and production costs of newspaper, magazine, radio, or television advertising to promote travel. Advertising shall be placed outside a [illegible]-mile radius of the attraction, event or area being promoted unless a major market (e.g., Chicago, St. Louis) falls within the [illegible]-mile radius;
      E) Membership dues for travel related associations or organizations;
      F) Billboards;
      G) Premium specialty items for promotional purposes with Department recognition (see subsection a)[illegible]);
      H) Production of videos for use in familiarization or travel trade industry;
      I) Salaries (see subsection (a)[illegible]);
      J) Posters and flyers distributed outside of service area;
      K) Projects distributed locally, if the bureau can demonstrate the project's ability to increase overnight stays in the service area;
      L) Marketing research studies; and
      M) "800" telephone lines for information.

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   2) Examples of projects ineligible for grant promotional funding include, but are not limited to:
      A) Any administrative expenses (xeroxing, postage, insurance, audits, accounting services, phone, rent, supplies, or equipment);
      B) Purchase of any alcoholic beverage;
      C) Feasibility studies; and
      D) Salaries of administrative or support staff.

c) Administrative Activities
   1) Examples of activities eligible for grant administrative funding including, but are not limited to:
      A) Any administrative expenses (xeroxing, postage, insurance, audits, accounting services, phone, rent, supplies, or equipment); and
      B) Salaries of administrative or support staff.
   2) Examples of activities ineligible for grant administrative funding include, but are not limited to:
      A) Lease purchase agreements for any items;
      B) Purchase of equipment;
      C) Purchase of any alcoholic beverage;
      D) Feasibility studies; and
      E) Penalties, fines, late payment fees, service or interest charges.

d) All project activities shall be subject to prior approval as stated under subsection (a) of this Section.

(Source: Amended at 20 Ill. Reg. ____________, effective ____________________________)

Section 550.50 Administrative Requirements

a) Grant Limitation: No bureau shall receive a grant for funds allocated in accordance with Section [illegible].b) in excess of $[illegible] ~~$[illegible]~~ per fiscal year. A bureau may contact the Department for information regarding the amount of funds it is eligible to receive in accordance with Section [illegible].

b) Administrative Costs: Administrative costs shall be limited to not more than [illegible]% of the grant funds awarded (see Section [illegible]).

c) Promotional Costs: Promotional costs shall be limited to not less than [illegible]% of the grant funds awarded (see Section [illegible](b)).

d) Matching Funds: Each bureau shall provide a dollar-for-dollar match for funds received under this program. Match expenditures shall equal or exceed grant funds expended, as well as any interest earned on grant funds which is also expended. Bureaus must receive prior Department approval (see ~~See~~ Section [illegible](a)) on contractual cooperative promotional project agreements used to satisfy match requirements. In-kind contributions shall not be used to satisfy match requirements.

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1) Local match shall:
   - A) be under the control of the bureau,
   - B) be identified in the bureau's grant application for the applicable fiscal year,
   - C) be expended during the applicable grant award period,
   - D) be supported by records of deposit and documentation of expenditures,
   - E) be expended by the bureau from funds in bureau accounts solely for the administration of the bureau and tourism promotion of their service area as a destination for overnight visitors, and
   - F) not be refunded to any local source of match and still qualify as match.
2) Sources of Eligible Match: The following monies, when received through a bureau's budget, may be used as match for <u>State</u> ~~state~~ grant funds:
   - A) <u>local</u> ~~Local~~ hotel motel taxes,
   - B) membership dues,
   - C) interest on local monies,
   - D) cash contributions, and
   - E) <u>federal</u> ~~Federal~~ dollars deposited directly to the grantee for tourism promotional purposes which do not require a match.
3) Ineligible Match:
   - A) In-Kind contributions such as donated services, donated space, donated equipment, services of volunteers, services in lieu of cash, or any non-monetary item;
   - B) State or federal funds other than those allowed in subsection d)(2)(E) above;
   - C) Monies used as match for other <u>State</u> ~~state~~ or federal grants;
   - D) Penalties, fines, late payment fees, or interest charges; and
   - E) Pass-through accounts.

e) Method of Compensation: Payments pursuant to a grant shall be subject to the availability of funds appropriated by the General Assembly.
   1) The bureau shall receive grant funds, as stipulated in the grant document, upon approval of its application by the Department and signature of the grant document by the Executive Director of the bureau and by the Department.
   2) Prior to funds being awarded, a bureau shall employ a full-time paid, professional Executive Director, devoting at least 20 hours per week to the development and growth of tourism within a bureau's region.

f) Reporting Requirements: The penalty for failure to comply with the timely submission of financial and programmatic reports described in subsections (f)(1), 2), and 3) below) shall be the withholding of subsequent monthly grant checks until all required reports are filed.

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The Department reserves the right to request additional information to clarify or document information on financial, programmatic, or personnel activities outlined in the reports.

1) Financial Reporting - Quarterly financial status reports shall be due no later than the 15th day of October, January, April and July and a lapse report shall be due September 15. The quarterly and lapse financial reports shall specify the grant number, grantee name, grant period, report period, bureau director's name signature, and date. Additionally, the quarterly and lapse financial reports shall contain the following information which must be broken down between programmatic costs (to be at least 80% of grant total awarded), administrative costs (not to exceed 20% of grant total awarded), and match costs:
   - A) Expenditure line-item breakout for State promotional costs indicating applicable report period which includes check number(s), project number(s), payee(s), description of purchase(s) service(s), amount of each check, and total promotional grant cost(s) expended for the report period.
   - B) Expenditure line-item breakout for State administrative costs indicating applicable report period which includes check number(s), project number(s), payee(s), description of purchase(s) service(s), amount of each check, and total administrative grant costs expended for the report period.
   - C) Expenditure line-item breakout for match costs indicating applicable report period which includes check number(s), payee(s), description(s) of purchase(s) service(s), amount of check(s), and total match cost(s) expended.
   - D) Expenditure Summary which includes vendor name(s), description(s) of services, actual cost(s), cancelled check number(s), and total(s) for all actual cost(s) listed.
   - E) Reimbursement Summary indicating report period which includes check number(s), check amount(s), reimbursement amount(s), cumulative balance, as well as totals for all figures.
   - F) Personnel activity information for personnel paid with ITCB grant funds which shall include: bureau name; grant number; employee name, payroll title, and signature; time period covered; supervisor's signature as approval; employee monthly rate; percent of time spent in each activity; percent of time paid from ITCB grant funds and from local funds; description of activity (if job description is not on file in the Illinois Bureau of Tourism Office).
   - G) Travel Expenditure Summary which includes applicable report period, traveler's name and signature, project number and title, date(s) of travel, destination(s), and allowable expenses (see subsection (h) of this Section).

~~2) Performance Measurement Summaries shall be submitted with quarterly reports and shall contain the following information:~~

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~~A) Conventions--total number of delegates and number of room nights~~

~~B) Motorcoach--total number of room nights, total number of overnight tours, and total number of day tours~~

~~C) Trade shows--total number of room nights, total number of attendees, and~~

~~D) Special events--total number of room nights, total number of attendees~~

29) Programmatic Reporting - Final programmatic reports shall be due September 15 for grant funds. Bureau name, grant period, name/title signature of bureau staff person submitting report, grant number, and date submitted shall be specified. A comparison of results of promotional activities for the program year to those projected in grantee's Fiscal Year Marketing Plan as submitted in the application must be provided, consisting of a brief narrative as to how the bureau's service area was benefited from these expenditures. Activity for LTCB-funded projects shall be broken down by project type as follows:

A) Meeting and Convention Market
B) Motorcoach and Group Tour Market
C) Festival Special Events
D) Consumer Leisure Market
E) Miscellaneous Projects

g) Financial Management Standards: A bureau's financial management systems shall be structured under the Accounting Standards of the Financial Accounting Standards Board of the American Institute of Certified Public Accountants (AICPA) (1211 Avenue of the Americas, New York, N.Y. 10036-8775) September 19, 1987 with no later amendments or editions. The bureau shall be accountable for all funds received under this program. The bureau shall maintain effective control and accountability over all funds, property, and other assets under the grant as required by the Department. The bureau shall keep records which detail the expenditures of grant and match funds and accurately document such expenditures.

h) Travel Expenses: Costs in accordance with the latest State of Illinois Department of Central Management Services Travel Regulations (80 Ill. Adm. Code 1800) shall be allowable for expenses of transportation, lodging, per diem, and related items incurred by employees who are in travel status for official business outside the bureau's service area. The bureau shall retain receipts as source documentation for travel expenses of its employees. The bureau shall also submit to the Department a completed report for travel expenses with the quarterly reports.

i) Monitoring: The Department shall on-site monitor each bureau funded under this program periodically by visits throughout the period covered under the grant agreement. The Department will notify the bureau at least two working days in advance of monitoring visits. The bureau's internal procedures, financial reporting, and program shall

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be evaluated for compliance with terms and conditions of the grant document. The Department reserves the right to request additional information prior to, during, or subsequent to monitoring visits.

j) Interest on Grant Funds: All interest earned on LTCB grant funds held by the bureau under the grant shall be spent on promotional projects approved by the Department, or returned to the Department at the end of the grant period.

k) Obligation of Grant Funds: All grant funds shall be obligated with respective vendor(s) prior to June 30 of the current fiscal year. Any grant funds not obligated (unobligated funds) shall be refunded to the Department by October 15. In addition, the bureau shall repay the Department for any funds that are determined by the Department through monitoring (subsection (i) of this Section) and audit (subsection (l) of this Section) to have been spent in violation of the grant document. All obligations shall be expended on or before prior to August 31.

l) Audits: The bureau shall conduct an audit of all grant and match program records which reflect the actual activities conducted and the actual costs and expenses incurred by the bureau using an independent certified public accountant, licensed by authority of the State of Illinois. The audit shall be conducted in accordance with generally accepted auditing standards adopted by the Codification of Statements on Auditing Standards (January 1983) of the AICPA and shall be submitted to the Department within twelve months after the end of the grantee's fiscal year. Any bureau determined to have misused program funds by fraud as a result of an audit shall be ineligible to apply for and receive funds under this program for a period not to exceed two years. The Department shall reserve the right to perform special audits of these funds during normal working hours.

m) Nondiscrimination: Bureaus shall refrain from unlawful discrimination in employment and will undertake affirmative action to assure equality of employment opportunity and eliminate the effects of past discrimination in accordance with the Illinois Human Rights Act (775 ILCS 5); Section 504 and the equal opportunity clause promulgated thereto of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794 (1994); The Age Discrimination Act of 1975, 42 U.S.C. 6101 et seq. (1994); and Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 1981 et seq. (1994).

n) Complaint Process: In the case of a grantee complaint, the Department shall follow the procedures outlined in 47 Ill. Adm. Code 10 (Review and Appeal Procedures).

o) Bids Solicitation: When the total cost for printed projects, purchase of premium items, or other projects deemed appropriate by the Department exceeds $5,000, a minimum of two bids using identical specifications shall accompany the project request. Evidence of compliance with this subsection (i.e., copies of at least two bid proposals) shall be submitted with project approval request. For any purchasing and/or printing costs where the lowest bid is not accepted,

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documentation (e.g., project specifications and quality requirements) shall be submitted with project approval request.

p) Bid Rigging/Rotating: Bureaus shall certify that they have not been barred from bidding on or receiving State contracts as a result of illegal bid rigging or bid rotating as defined Sections 33E-3 and 33E-4 of the Criminal Code of 1961 (720 ILCS 5/33E-3 and 33E-4).

q) Separate Account: A separate bank account shall be established for the purpose of this program. Two authorizing signatures shall be required for the account. Only grant funds received under this program shall be deposited in this account unless local funds are deposited in the account to maintain a minimum balance to avoid finance charges.

r) Suspension and Termination:

1) If a bureau has failed to comply with the terms and conditions of the grant document, the Department shall suspend the grant and withhold further payments until the grant is terminated, or the bureau has achieved compliance. The Department will determine that a bureau has failed to comply with the terms and conditions of a grant when:

A) The bureau has been notified in writing of the existence of circumstances which the Department considers to be inconsistent with the terms and conditions of the grant (e.g., consistent failure to submit required reports or evidence of fraud and abuse); and

B) The bureau fails to develop, submit, and implement a corrective action plan within 45 days after of the Department's notice.

2) A grant shall be terminated in the absence of full State funding; if the Department determines that the bureau has failed to comply with the terms and conditions of the grant in whole or in part; or if the Department and the bureau agree to terminate the grant.

s) Reallocation of Funds: The grantee shall be required to identify that amount of its grant funds which will not be fully obligated by the end of the fiscal year, on or before May 1 of the current fiscal year. The grant document shall be decreased by the specified amount and such funds shall be reallocated by the Department to grantees who apply for (see application procedures specified in Section 550.60(d)) and can utilize available funds by the end of the fiscal year for new promotional projects.

t) Bribery: The bureau's executive director/chief executive officer certifies to the best of his/her knowledge that no official, agent, or employee of the grantee has been convicted of bribery or attempting to bribe an officer or employee of the State of Illinois, nor has any such officer, agent, or employee made an admission of guilt of such conduct which is a matter of record.

u) Conflict of Interest:

1) The bureau shall certify that no person who in any manner governs, advises, consults with, is employed by, is an officer

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of, or is an elected or appointed official of the bureau, or any governing board or entity of the bureau, nor any husband, wife, or minor child of that person, shall be in any manner interested, either directly or indirectly, in any contract or work awarded by the bureau unless the following requirements are met:

A) The bureau notifies the Department, in writing, of the nature of the conflict of interest and receives written notification of approval from the Department to proceed with the process of bidding or letting of the contract. The Department shall approve if the bureau demonstrates that the best interest of the State outweighs outweighs the conflict of interest at issue; and

B) The bureau discloses, for the record, the existence of the conflict of interest at any meeting held to consider the acceptance of bids or letting of contracts; the interested person abstains from discussing, voting on, or influencing the acceptance of bids or letting of contracts, and removes himself or herself from the meeting room during the time the bids or contracts are discussed and voted upon.

2) Violations of this provision shall result in suspension or revocation of the grant, or both, and reimbursement to the Department by the bureau of grant funds. Violators shall also be criminally liable under other applicable State laws and subject to actions up to and including felony prosecution.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

ILLINOIS COMMUNITY COLLEGE BOARD

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Administration of the Illinois Public Community College Act

2) Code Citation: 23 Ill. Adm. Code 1501

3) Section Numbers: Proposed Action:
1501.501 Amendment
1501.520 New

4) Statutory Authority: 110 ILCS 805/2-16.02

5) A Complete Description of the Subjects and Issues Involved: The Lincoln's Challenge Program is administered by the Illinois Department of Military Affairs. Upon successful completion of that program, students qualify for a scholarship to a community college. The Lincoln's Challenge Scholarship Grant is a special appropriation received by the ICCB from the Governor and the General Assembly. These scholarships provide an opportunity for graduates of Lincoln's Challenge to transition easily into higher education by attending one of the 49 public community colleges in the State. The scholarships grants can be used to cover the cost of education that includes tuition, books, fees and required educational supplies.

6) Will these proposed amendments replace emergency rules currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives (if applicable): Not Applicable.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments to:

Jill O'Shea
Director for Governmental Relations
Illinois Community College Board
509 South Sixth Street, Suite 400
Springfield, IL 62701-1874
(217) 785-0213

All written comments received within 45 days after this issue of the *Illinois Register* will be considered.

12) Initial Regulatory Flexibility Analysis: The Illinois Community College Board has determined that this rulemaking will not affect small business.

ILLINOIS COMMUNITY COLLEGE BOARD

NOTICE OF PROPOSED AMENDMENTS

13) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included in either of the 2 most recent agendas because: This rulemaking was not anticipated at the time of the last regulatory agenda.

The full text of the Proposed Amendments begins on the next page.

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NOTICE OF PROPOSED AMENDMENTS

TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER VII: ILLINOIS COMMUNITY COLLEGE BOARD

PART 1501
ADMINISTRATION OF THE ILLINOIS PUBLIC COMMUNITY COLLEGE ACT

SUBPART A: ILLINOIS COMMUNITY COLLEGE BOARD ADMINISTRATION

Section
1501.101 Definition of Terms
1501.102 Advisory Groups
1501.103 Rule Adoption (Recodified)
1501.104 Manuals
1501.105 Advisory Opinions
1501.106 Executive Director
1501.107 Information Request (Recodified)
1501.108 Organization of ICCB (Recodified)
1501.109 Appearance at ICCB Meetings
1501.110 Appeal Procedure
1501.111 Reporting Requirements (Repealed)
1501.112 Certification of Organization (Repealed)
1501.113 Administration of Detachments and Subsequent Annexations
1501.114 Recognition

SUBPART B: LOCAL DISTRICT ADMINISTRATION

Section
1501.201 Reporting Requirements
1501.202 Certification of Organization
1501.203 Delineation of Responsibilities
1501.204 Maintenance of Documents or Information
1501.205 Recognition Standards (Repealed)

SUBPART C: PROGRAMS

Section
1501.301 Definition of Terms
1501.302 Units of Instruction, Research, and Public Service
1501.303 Program Requirements
1501.304 Statewide and Regional Planning
1501.305 College, Branch, Campus, and Extension Centers
1501.306 State or Federal Institutions (Repealed)
1501.307 Cooperative Agreements and Contracts
1501.308 Reporting Requirements
1501.309 Course Classification and Applicability

SUBPART D: STUDENTS

ILLINOIS COMMUNITY COLLEGE BOARD

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Section
1501.401 Definition of Terms
1501.402 Admission of Students
1501.403 Student Services
1501.404 Academic Records
1501.405 Student Evaluation
1501.406 Reporting Requirements

SUBPART E: FINANCE

Section
1501.501 Definition of Terms
1501.502 Financial Planning
1501.503 Audits
1501.504 Budgets
1501.505 Nonresident Student Tuition Calculations
1501.506 Published Financial Statements
1501.507 Credit Hour Grants
1501.508 Special Populations Grants
1501.509 Workforce Preparation Grants
1501.510 Reporting Requirements
1501.511 Chart of Accounts
1501.514 Business Assistance Grants (Repealed)
1501.515 Advanced Technology Equipment Grants
1501.516 Capital Renewal Grants
1501.517 Retirees Health Insurance Grants
1501.518 Uncollectible Debts
1501.520 Lincoln's Challenge Grants

SUBPART F: CAPITAL PROJECTS

Section
1501.601 Definition of Terms
1501.602 Approval of Capital Projects
1501.603 State Funded Capital Projects
1501.604 Locally Funded Capital Projects
1501.605 Project Changes
1501.606 Progress Reports (Repealed)
1501.607 Reporting Requirements
1501.608 Approval of Projects in Section 3-20.3.01 of the Act
1501.609 Completion of Projects Under Section 3-20.3.01 of the Act
1501.610 Demolition of Facilities

SUBPART J: STATE COMMUNITY COLLEGE

Section
1501.701 Definitions of Terms
1501.702 Applicability

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1501.703 Recognition
1501.704 Programs
1501.705 Finance
1501.706 Personnel
1501.707 Facilities

SUBPART H: PERSONNEL

Section
1501.801 Definition of Terms
1501.802 Sabbatical Leaves

AUTHORITY: Implementing and authorized by Articles II and III and Section 6-5.3 of the Public Community College Act [110 ILCS 805/Arts. II and III and 6-5.3].

SOURCE: Adopted at 6 Ill. Reg. 14262, effective November 3, 1982; codified at 7 Ill. Reg. 2332; amended at 7 Ill. Reg. 16118, effective November 22, 1983; Sections 1501.103, 1501.107 and 1501.108 recodified to 2 Ill. Adm. Code 5175 at 8 Ill. Reg. 6032; amended at 8 Ill. Reg. 14262, effective July 25, 1984; amended at 8 Ill. Reg. 19383, effective September 28, 1984; emergency amendment at 8 Ill. Reg. 22603, effective November 7, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 24299, effective December 5, 1984, for a maximum of 150 days; amended at 9 Ill. Reg. 7691, effective March 13, 1985; amended at 9 Ill. Reg. 9470, effective June 11, 1985; amended at 9 Ill. Reg. 16813, effective October 21, 1985; amended at 10 Ill. Reg. 1612, effective January 31, 1986; amended at 10 Ill. Reg. 14658, effective August 22, 1986; amended at 11 Ill. Reg. 7606, effective April 8, 1987; amended at 11 Ill. Reg. 18150, effective October 27, 1987; amended at 12 Ill. Reg. 6660, effective March 25, 1988; amended at 12 Ill. Reg. 15973, effective September 23, 1988; amended at 12 Ill. Reg. 16699, effective September 23, 1988; amended at 12 Ill. Reg. 19691, effective November 15, 1988; amended at 13 Ill. Reg. 1182, effective January 13, 1989; amended at 13 Ill. Reg. 14304, effective September 12, 1989; emergency amendment at 14 Ill. Reg. 299, effective November 9, 1989, for a maximum of 150 days; emergency amendment expired on April 9, 1990; amended at 14 Ill. Reg. 4126, effective March 1, 1990; amended at 14 Ill. Reg. 10762, effective June 25, 1990; amended at 14 Ill. Reg. 11771, effective July 9, 1990; amended at 14 Ill. Reg. 12997, effective August 20, 1990; expedited correction at 18 Ill. Reg. 3027, effective August 20, 1990; amended at 15 Ill. Reg. 10929, effective July 12, 1991; amended at 16 Ill. Reg. 12445, effective July 24, 1992; amended at 16 Ill. Reg. 17621, effective November 6, 1992; amended at 17 Ill. Reg. 1853, effective February 2, 1993; amended at 18 Ill. Reg. 4835, effective March 9, 1994; amended at 18 Ill. Reg. 9306, effective June 1, 1994; amended at 19 Ill. Reg. 1299, effective February 14, 1995; amended at 19 Ill. Reg. 1816, effective March 10, 1995; amended at 19 Ill. Reg. 7515, effective May 26, 1995; amended at 20 Ill. Reg. _____, effective _____.

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SUBPART E: FINANCE

Section 1501.501 Definition of Terms

Advanced Technology Equipment Grant. The advanced technology equipment grant provides state funds to Illinois public community colleges for the procurement of equipment necessary to upgrade curricula impacted by technological changes. (See Section 2-16 of the Act.)

Annual Financial Statement. The "annual financial statement," which is required to be published by a district, consists of two parts:

an annual financial report, which includes a statement of revenues and expenditures along with other basic financial data; and

an annual program report, which provides a narrative description of programs offered, goals of the district, and student and staff data.

Attendance at Mid-Term. A student is "in attendance at mid-term" in a course if the student is currently enrolled in and actively pursuing completion of the course.

Auditor. An auditor is a person who enrolls in a class without intent to obtain academic credit and whose status as an auditor is declared by the student, approved by college officials, and identified on college records prior to the end-of-registration date of the college for that particular term.

Business Assistance Centers and Workforce Preparation Offices. Business assistance centers and workforce preparation offices are entities at community colleges that conduct, coordinate, and assist with workforce preparation activities.

Capital Renewal Grants. Capital renewal grants are state grants allocated proportionally to each community college district based on the latest fall on-campus nonresidential gross square feet of facilities as certified by the ICCB. Such grants are to be utilized for miscellaneous capital improvements such as rehabilitation, remodeling, improvement, and repair; architect/engineer services; supplies, fixed equipment, and materials; and all other expenses required to complete the work.

"Lincoln's Challenge Scholarship Grants." The Lincoln's Challenge Program is administered by the Illinois Department of Military Affairs. Upon successful completion of that program, students qualify

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for a scholarship to a community college. The Lincoln's Challenge Scholarship Grant is a special appropriation received by the ICCB from the Governor and the General Assembly. These scholarships provide an opportunity for graduates of Lincoln's Challenge to transition easily into higher education by attending one of the 49 public community colleges in the State. The scholarship grants can be used to cover the cost of education that includes tuition, books, fees and required educational supplies.

Residency - Applicability-Verification of Status. As part of verification that its credit hours are eligible to receive ICCB grants, each community college district shall adopt a process for verifying the residency status of its students and shall file a description of this process with the ICCB by July 1, 1990. The process shall include the methods for verifying residency as defined in the general provisions, special state provisions, and district provisions of this subsection. Each district shall file descriptions of any revisions to its process with the ICCB prior to their implementation.

Residency - General Provisions. The following provisions apply both to state and district residency definitions:

To be classified as a resident of the State of Illinois or of the community college district, each student shall have occupied a dwelling within the state or district for at least 30 days immediately prior to the date established by the district for classes to begin.

The district shall maintain documentation verifying state or district residency of students.

Students occupying a dwelling in the state or district who fail to meet the 30-day residency requirement may not become residents simply by attending classes at a community college for 30 days or more.

Students who move from outside the state or district and who obtain residence in the state or district for reasons other than attending the community college shall be exempt from the 30-day requirement if they demonstrate through documentation a verifiable interest in establishing permanent residency.

Residency - District Provisions. Students shall not be classified as residents of the district where attending even though they may have met the general 30-day residency provision if they are:

federal job corps workers stationed in the district;

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inmates of state or federal correctional/rehabilitation institutions located in the district;

full-time students attending a postsecondary educational institution in the district who have not demonstrated through documentation a verifiable interest in establishing permanent residency; and

students attending under the provisions of a chargeback or contractual agreement with another community college.

Residency - Special State Provisions. Students shall be classified as residents of the state without meeting the general 30-day residency provision if they are:

federal job corps workers stationed in Illinois;

members of the armed services stationed in Illinois;

inmates of state correctional/rehabilitation institutions located in Illinois; or

employed full time in Illinois.

Special Populations Grant. A "special populations grant" provides funding for:

Special or extra services to assist special populations students to initiate, continue, or resume their education, including tutoring, educational and career counseling, referrals to external agencies, and testing/evaluation to determine courses or services needed by a special populations student.

Courses (not funded through credit hour grants) to provide the academic skills necessary to remedy or correct educational deficiencies to allow the attainment of educational goals, including remedial, adult basic education, adult secondary education, and English as a Second Language courses.

Special Populations Student. A "special populations student" is a student with a social, physical, developmental, or academic disability that makes it difficult for such a student to adapt to a college environment designed for the nonspecial populations student. This may include students from minority racial ethnic groups. Colleges shall designate which of their students are special populations as determined by teacher and counselor evaluations and various standardized tests selected by the colleges.

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Workforce Preparation Activities. Workforce preparation activities create or retain jobs and increase employment opportunities.

Workforce Preparation Grants. Workforce preparation grants provide funds for conducting workforce preparation activities.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 1501.520 Lincoln's Challenge Grants

a) Lincoln's Challenge Scholarship Grants shall be vouchered to community colleges.

b) Students can qualify for their first Lincoln's Challenge Scholarship Grant if they meet the following criteria:
   1) Complete the Lincoln's Challenge program;
   2) Complete the GED or pursuing the completion of the GED;
   3) Enroll at one of the 49 Illinois public community colleges in a certificate or degree program within one year after graduation from the Lincoln's Challenge Program;
   4) Carry an academic load of at least six credit hours each term except the summer term;
   5) Present the "notification of award" letter signed by the Executive Director of the Illinois Community College Board to the community college at the time of registration.

c) The scholarship is limited to $1,000 per student per semester.

d) The scholarship shall be applied only to the cost of tuition, books, fees and required educational supplies.

e) The grant will only reimburse the college at the in-district tuition rate.

f) In order to receive the reimbursement, colleges must submit the following information for each student:
   1) Name;
   2) Social Security Number;
   3) Program of study;
   4) Course Schedule;
   5) Bill with costs broken out by tuition, fees, books and educational supplies; and
   6) GPA and course completions from previous semester - if continuing student.

g) In order to remain qualified for a Lincoln's Challenge Scholarship, each student must:
   1) Submit a letter of application to the Illinois Community College Board requesting continuation of the scholarship for the next semester. The letter must be postmarked by August 1 for application to the fall term and January 1 for application to the spring term; and
   2) Comply with academic standards as defined by college policy. The

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first semester minimum grade point average may be waived as a determining factor of academic standards achievement if the student's academic advisor concludes that extenuating circumstances existed; and
   3) Submit documentation showing the academic status and the number of credit hours completed during the last term of enrollment at the college.

h) Students can be awarded scholarship funds for three successive years, or a maximum of 64 credit hours (or more if completing an associate in applied science degree requiring additional credit hours) to be used toward the completion of a degree or certificate program.

i) The number of scholarships awarded each year is contingent upon the amount of funds appropriated. The scholarships cannot be guaranteed to students even if all criteria are met.

(Source: Added at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENT(S)

1) Heading of the Part: Designation of Restricted Waters in the State of Illinois

2) Code Citation: 17 Ill. Adm. Code 2030

3) Section Numbers: 2030.20 — Proposed Action: Amendment

4) Statutory Authority: Implementing and authorized by Sections 5-7 and 5-12 of the Boat Registration and Safety Act (625 ILCS 45/5-7 and 5-12).

5) A Complete Description of the Subjects and Issues Involved: This Part is being amended due to public safety concerns resulting from heavy boat use. The area known as Savanna Slough in Region I is being added to the list of areas designated as Slow, No Wake.

6) Will this rulemaking replace any emergency rulemaking currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rule may be submitted in writing for a period of 45 days following publication of this notice to:

Jack Price
Department of Natural Resources
524 S. Second Street
Springfield, IL 62701-1787
217/782-1809

12) Initial Regulatory Flexibility Analysis: This rulemaking does not affect small businesses, municipalities or not for profit corporations.

13) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not submitted on either of the 2 most recent agendas because: The Department did not anticipate amending the rule.

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENT(S)

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
SUBCHAPTER e: LAW ENFORCEMENT

PART 2030
DESIGNATION OF RESTRICTED WATERS IN THE STATE OF ILLINOIS

Section
2030.10 General Regulations
2030.10 General Regulations (Repealed)
2030.15 Designation of Restricted Waters by the Department of Natural Resources
2030.20 Region I - Designated Restricted Boating Areas
2030.30 Region II - Designated Restricted Boating Areas
2030.40 Region III - Designated Restricted Boating Areas
2030.50 Region IV - Designated Restricted Boating Areas
2030.60 Region V - Designated Restricted Boating Areas (Repealed)
2030.70 Riverboat Gambling Casinos - Designated Restricted Boating Areas

AUTHORITY: Implementing and authorized by Sections 5-7 and 5-12 of the Boat Registration and Safety Act (625 ILCS 45/5-7 and 5-12).

SOURCE: Adopted at 5 Ill. Reg. 8763, effective August 25, 1981; codified at 5 Ill. Reg. 10617; amended at 9 Ill. Reg. 4789, effective April 2, 1985; amended at 11 Ill. Reg. 9519, effective May 5, 1987; emergency amendment at 12 Ill. Reg. 8745, effective May 15, 1988, for a maximum of 150 days; emergency expired September 20, 1988; emergency amendment at 12 Ill. Reg. 12111, effective July 6, 1988, for a maximum of 150 days; emergency expired December 12, 1988; amended at 12 Ill. Reg. 16707, effective September 30, 1988; amended at 12 Ill. Reg. 20472, effective November 28, 1988; corrected at 13 Ill. Reg. 967; emergency amendment at 13 Ill. Reg. 2878, effective February 21, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 12914, effective July 21, 1989; amended at 16 Ill. Reg. 3483, effective May 26, 1992; amended at 19 Ill. Reg. 7519, effective May 26, 1995; emergency amendment at 19 Ill. Reg. 11967, effective August 3, 1995, for a maximum of 150 days; amended at 20 Ill. Reg. 750, effective December 29, 1995; amended at 20 Ill. Reg. 7864, effective June 3, 1996; recodified by changing the name from Department of Conservation to Department of Natural Resources at 20 Ill. Reg. 9389; amended at 20 Ill. Reg. _____, effective _____.

Section 2030.20 Region I - Designated Restricted Boating Areas.

a) The following portions of the Rock River are designated as Slow, No Wake areas:
   1) An area of the Rock River located at Moonlite Bay, 4 miles east of Sterling and 6 miles west of Dixon, Illinois.
   2) The portion of the Rock River 1/4 mile above the dam at Oregon, Illinois, at the docking area at Lowden Memorial Park.

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b) The following portions of the Fox River are designated as Slow, No Wake areas:
   The portion of the Fox River between the Main Street bridge of the City of Ottawa and the mouth of the Fox River at the confluence of the Illinois River.

c) The following portions of the Illinois River are designated as Slow, No Wake areas:
   1) The portion of the Illinois River from the Burlington Northern R.R. bridge in the City of Ottawa to the upstream side of the mouth of the Fox River.
   2) The area of the Illinois River near the Spring Bay boat harbor at Spring Bay, Illinois.
   3) An area of the Illinois River at the Woodford County Conservation area, 7 miles north of Spring Bay off Route 87.
   4) An area of the Illinois River located at the Detweiller Marina, Peoria, Illinois.
   5) An area of the Illinois River at Alfrisco Harbor, Peoria Heights, Illinois.
   6) An area located at the Sobowski Marina, Peoria Heights, Illinois.
   7) An area located at the Illinois Valley Yacht Club, Peoria Heights, Illinois.
   8) An area at Henry, Illinois, on the west side of the River from Browns Landing to 300 yards north of the bridge.
   9) The Lacon Boat Club Dock, Lacon, Illinois.
   10) The boat harbor at Lacon, Illinois.
   11) An area at the South Shore Boat Club, Peru, Illinois.
   12) The harbor of Starved Rock Marina, Ottawa, Illinois.
   13) The waters of the Illinois River beginning in front of the Pekin Boat Club launching ramp.

d) The following portions of the Mississippi River are designated as Slow, No Wake areas:
   1) An area bordering the Savanna Park waterfront, extending from a jetty south of the Ritchie Boat Dock, north to a jetty north of the Kindell Marina.
   2) An area in Waeky Chute which runs through the Andalusia Islands located 4 miles west of Andalusia.
   3) An area at the launching ramp and harbor of the Rock Island Boat Club located at the foot of 18th Avenue in Rock Island.
   4) An area at the harbor and boat ramp in front of the Legion Hall at Cordova, Illinois.
   5) An area located at the boat ramps, City of Moline, between 26th Street and 24th Street and River Drive.
   6) An area near the launching ramps and bathing beach at Keithsburg, Illinois.
   7) An area in the chute connecting Sturgeon Bay and the Mississippi River at New Boston, Illinois.
   8) An area near the boat ramp and floating gas station at the end of Route 17 at New Boston.

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   9) An area at Shokohon, Illinois.
   10) An area in the fish preserve lock and dam 19 at Hamilton, Illinois.
   11) The public launching area 3 miles north above the dam at Hamilton.
   12) The waters of Harris Slough Mississippi River backwaters at the Galena Boat Club, 3 miles south of Galena, Illinois.
   13) The waters encompassing the cut starting at the mouth of the cut on Deadman's Slough, then northward approximately 250 feet to the confluence of the Harris and Keonough Sloughs.
   14) The backwater section of the Mississippi River (river mile marker 479.8) that starts at the Harbor opening of Potter's Lake, Sunset Park, Rock Island and covers the entire lake area.
   15) The area of Cattail Slough off the Mississippi River, located south of Fulton, Whiteside County, 7/10 mile in length, 150 yards wide, starting on the north at the Chicago and Northwestern R.R. bridge and extending south 7/10 of a mile to the first narrows.
   16) The waters of the south entrance to Chandler Slough lying upstream from the north boundary of the U.S. Fish and Wildlife Service property up to and including the Bent Prop Marina harbor area.
   17) The waters of Prentress Lake lying upstream from the boat ramp at Charlies Boat Dock, including the adjacent sand pit harbor area.
   18) An area of the Mississippi River in the vicinity of the Lazy River Marina of Savanna, Illinois extending from the upper limit of the dredge cut at Miller's Lake to a point north of the Miller's Hollow public launching ramp.
   19) An area located approximately at Mississippi River mile 536.6 known as Savanna Slough from the Soo Line railroad bridge north to the north point of the Savanna Park District island as posted by signs or buoys.

e) The following waters shall be designated as restricted waters as described below:
   1) NO BOATS
      A) The swimming area at Martin Park, Loves Park, Illinois.
      B) The swimming area at Albany Beach located in Albany Township.
      C) The swimming area at the Santa Fe Island bar, approximately 4 miles north of Savanna.
      D) The head of Big Island and 1 1/2 miles north of Oquawka, Illinois.
      E) The Boy Scout Camp located on Lake Cooper, Mississippi River.
      F) The waters of the four chutes of Argyle Lake, approximately 2 miles north of Colchester, Illinois.
      G) The water 600 feet above and 150 feet below dams 12, 13, 14, 15, 16, 17 and 18 on the Mississippi River.
   2) NO SKI - It shall be unlawful to water ski in the following

DEPARTMENT OF NATURAL RESOURCES

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designated waters:
That area of the inside cut of the Mississippi River, opening directly into Frentress Lake, includes the area from the north to the south entrances from the river slough, inclusive, east of Mile Post 576.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED RULES

1) Heading of the Part: Operation of Watercraft Carrying Passengers for Hire on Illinois Waters

2) Code Citation: 17 Ill. Adm. Code 2080

3)

Section Numbers:	Proposed Action:
2080.10	New Section
2080.20	New Section
2080.30	New Section
2080.40	New Section
2080.50	New Section
2080.60	New Section
2080.70	New Section
2080.80	New Section
2080.90	New Section

4) Statutory Authority: Implementing and authorized by Sections 2-1, 2-2, 7-1, 7-2, 7-3, 7-4, 7-5, 7-6, 7-7, 7-8, 7-9 and 8-3 of the Boat Registration and Safety Act [625 ILCS 45/2-1, 2-2, 7-1, 7-2, 7-3, 7-4, 7-5, 7-6, 7-7, 7-8, 7-9 and 8-3].

5) A Complete Description of the Subjects and Issues Involved: This rule sets out methods of computing weight capacity of boats carrying passengers for hire, dry dock inspection requirements for each 5-year inspection, annual dockside inspection requirements, inspections after major accidents, equipment requirements, who may inspect, and what happens if fail to pass inspection. Provides for suspension of license for violations and exempts Coast Guard inspected vessels. Also exempts vessels carrying not more than 6 passengers from dry dock inspections.

6) Will this rulemaking replace any emergency rulemaking currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rule may be submitted in writing for a period of 45 days following publication of this notice to:

Jack Price
Department of Natural Resources

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED RULES

524 S. Second Street
Springfield, IL 62701-1787
217/782-1809

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Watercraft carrying passengers for hire.

B) Reporting, bookkeeping or other procedures required for compliance: Owner is required to submit a marine inspection report for licensing. Owner is required to submit to a dockside marine inspection annually and a dry dock inspection every 5 years.

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda in which this rulemaking was summarized: This rule was not included on either of the 2 most recent agendas because: We did not know when the rulemaking would be prepared for filing.

The full text of the Proposed Rules begins on the next page:

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED RULES

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
SUBCHAPTER e: LAW ENFORCEMENT

PART 2080
OPERATION OF WATERCRAFT CARRYING PASSENGERS FOR HIRE ON ILLINOIS WATERS

Section
2080.10 Introduction
2080.20 Definitions
2080.30 Applicability
2080.40 Dry Dock Inspection
2080.50 Dockside Inspection
2080.60 Licensing Requirements
2080.70 Certification
2080.80 Misuse of License or Certificate
2080.90 Suspension and Revocation of Certificates and Licenses

AUTHORITY: Implementing and authorized by Sections 2-1, 2-2, 7-1, 7-2, 7-3, 7-4, 7-5, 7-6, 7-7, 7-8, 7-9 and 8-3 of the Boat Registration and Safety Act [625 ILCS 45/2-1, 2-2, 7-1, 7-2, 7-3, 7-4, 7-5, 7-6, 7-7, 7-8, 7-9 and 8-3].

SOURCE: Adopted at 20 Ill. Reg. _____, effective _____.

Section 2080.10 Introduction

The State of Illinois, Department of Natural Resources, hereby announces the rules and regulations supplementing the provisions of the Boat Registration and Safety Act of 1959 [625 ILCS 45].

Section 2080.20 Definitions

a) Department - the Department of Natural Resources.
b) Dockside Inspection - an examination of a watercraft in the water so that all equipment and systems may be inspected.
c) Dry Dock Inspection - an examination of a watercraft out of the water and supported so all the exterior and interior of the watercraft may be examined.
d) General Maintenance - dry docking or hauling out of a watercraft for painting or cleaning the hull and rudder, or the changing of a propeller shaft and associated bearings.
e) Good Marine Practice and Standards - those methods and ways of maintaining, operating, equipping, repairing and restructuring watercraft as determined by the marine inspector. The marine inspector shall use commonly accepted standards, including 46 CFR

Subchapters T, K, K' and H, the standards of the American Boat and Yacht Council, the standards of the American Bureau of Shipping, and other appropriate generally accepted standards as sources of reference.

f) Independent Certifier - any person who, through his background, experience, or training, is qualified to inspect a vessel for equipment carriage requirements as set forth in this Part, and certify compliance to the Department. Such person may include, but not be limited to, a marine inspector as defined in this Part, or a qualified member of the U.S. Coast Guard Auxiliary, but may not include the owner, anyone related to the owner, or any employee of the vessel being inspected.

g) Inland Waters - all waters of the State, except navigable waters.

h) Marine Inspector - a marine surveyor with at least five years experience, or a professional engineer licensed by the Illinois Department of Professional Regulation.

i) Navigable Waters - those waters of the State over which the State of Illinois and the United States Coast Guard exercise joint jurisdiction, including Lake Michigan, to the upstream limit of navigation as determined by the United States Department of the Army, Corps of Engineers.

j) Open Boat - a watercraft, either with or without engines or motors, which has its engine, fuel tank compartments, and other spaces, except weather enclosures, open to the atmosphere and arranged to prevent or preclude the entrapment of explosive and flammable gases and vapors within the watercraft.

k) Owner - a person who claims lawful possession of a watercraft by virtue of legal title or equitable interest therein which entitles him or her to possession. "Owner" also means a person acting on the behalf of the owner in all matters concerning the watercraft.

l) Personal Flotation Device - a United States Coast Guard approved lifesaving device.

m) State Boating Law Administrator - the Department of Natural Resources law enforcement officer assigned to administer boating statutes and rules for boating safety.

n) Suitable - the marine inspector has determined an item is in keeping with good marine practice and standards.

Section 2080.30 Applicability

a) This Part does not apply to watercraft required to be inspected by the United States Coast Guard, under 46 CFR Subchapters T, K, K' and H, for the purpose of carrying passengers for hire.

b) This Part shall apply to all other watercraft, as defined in the Act, carrying passengers for hire on waters of this State.

Section 2080.40 Dry Dock Inspection

a) For watercraft carrying more than six passengers for hire, as defined by the United States Coast Guard, already licensed to carry passengers for hire in the State of Illinois prior to the effective date of this Part, the initial dry dock inspection shall be required as follows:
   1) Watercraft having a registration number ending with either 0 or 1 shall be inspected before being licensed in 1997.
   2) Watercraft having a registration number ending with either 2 or 3 shall be inspected before being licensed in 1998.
   3) Watercraft having a registration number ending with either 4 or 5 shall be inspected before being licensed in 1999.
   4) Watercraft having a registration number ending with either 6 or 7 shall be inspected before being licensed in 2000.
   5) Watercraft having a registration number ending with either 8 or 9 shall be inspected before being licensed in 2001.

b) Inspection Procedures for Watercraft Carrying More Than Six Passengers For Hire, as defined by the United States Coast Guard in 46 CFR Subchapters T, K, K', and H.
   1) Before carrying passengers for hire, a watercraft shall successfully complete a dry dock inspection conducted by a marine inspector. The Department shall subsequently require successful completion of a dry dock inspection every 5 years.
   2) Before an inspection, the owner of a watercraft shall remove or effectively store all associated equipment, including fishing gear, coolers, and personal belongings onboard the watercraft, which could impede the inspection process.
   3) The owner of a watercraft shall open or remove all hatches and inspection ports before or during an inspection and shall have the watercraft in a reasonably clean and orderly condition.
   4) To determine that a watercraft is seaworthy and in good and serviceable condition, the owner of a vessel shall permit the marine inspector to inspect the entire interior and exterior of the vessel, including all components, machinery, and associated equipment.
   5) When the marine inspector has reasonable cause to believe that the seaworthiness or the sound structure of the watercraft may be impaired, the owner of the watercraft may be required to remove sections or portions of the lining, decking, ceiling, or other obstructions that may obscure any part of the watercraft so that the seaworthiness or sound structure may be determined.

c) Watercraft Passenger Capacity; Determination
   1) On watercraft that do not have or are not required to have a watercraft capacity plate, the maximum passenger capacity shall be determined by applying any one of the following criteria which result in the allowance of the greatest number of passengers.
      A) One passenger per 30 inches of rail space available to passengers at the watercraft's sides and across the transom.
      B) One passenger per 10 square feet of deck area available for

passenger use. In computing the deck area, the areas occupied by concession stands, toilets and washrooms, companionways, and stairways shall be excluded.

C) One passenger per 18 inches of width of fixed seating provided.

2) On vessels that have or are required to have vessel capacity plates, the passenger capacity shall be determined by applying either of the following criteria which result in the allowance of the greatest number of persons without exceeding the capacity plate maximums.

A) Weight capacity - maximum motor and gear weight) / 150 = number of passengers.

B) Boat length X boat beam) / 15 = number of passengers.

3) The marine inspector shall calculate the number of passengers which may safely be transported on watercraft carrying passengers for hire. The number shall be set forth on the certificate of inspection.

d) Vessel damage, repairs, and alterations; reports; repair and alteration standards; modification of corrections and repairs; determination of unsafe vessel; modification and inspection exception.

1) When a vessel is involved in an accident causing major physical damage, has structural damage, or is to be hauled out and dry docked to carry out major repairs or alterations affecting the vessel's seaworthiness, the owner of the vessel shall immediately report to a marine inspector the nature of the damage, repairs, or alterations. Physical damage does not include breakage of glass, lights, or decorative items.

2) All repairs and alterations shall be done in accordance with good marine practice and standards and approved by a marine inspector before the work is started. Drawings, sketches, or written specifications may be required by the marine inspector depending on the nature and extent of the repairs or alterations.

3) The owner of a vessel shall not allow the vessel to be returned to service or returned to the water until all repairs or alterations have been completed and the vessel has been reinspected and approved by a marine inspector. A marine inspector shall reinspect the watercraft as soon as possible after notification by the owner that the repairs and alterations have been completed.

4) When corrections or repairs to the watercraft or associated equipment are required as a result of an inspection by a marine inspector, the owner of the vessel shall notify the marine inspector when the corrections or repairs have been made.

5) When during the course of an inspection, the marine inspector finds equipment or conditions which are not addressed in this Part and which are unsafe or jeopardize the safety of the passengers carried onboard, the marine inspector shall require the condition be corrected or the equipment removed from the watercraft.

6) When it is determined by the marine inspector that a watercraft, because of its construction or design, or both, is not safe to carry passengers for hire, a certificate of inspection shall not be issued. The owner, if not satisfied with the decision of the Department, may seek relief by requesting a formal hearing as authorized by 17 Ill. Adm. Code 2530, Department Formal Hearings Conducted for Rulemaking and Contested Cases.

7) Notification and inspection shall not be required for general maintenance dry docking or hauling out.

e) Inspection Exemptions

1) Watercraft carrying not more than six passengers for hire, as defined by the United States Coast Guard in 46 CFR Subchapters T, K, K', and H, shall not be required to be inspected under the provisions of this Section.

2) Watercraft registered in another state which have been inspected under similar provisions in that state shall not be required to be inspected under the provisions of this Section.

Section 2080.50 Dockside Inspection

a) Annual Inspection
All watercraft subject to this Part shall be inspected annually under the provisions of this Section, except as provided in Section 2080.40 of this Part.

b) Inspection Procedures for Watercraft Carrying More Than Six Passengers For Hire, as defined by the United States Coast Guard in 46 CFR Subchapters T, K, K', and H.
The owner of a vessel shall, at the dockside inspection, submit his vessel for inspection by a marine inspector and shall operate or cause to be operated all equipment and systems to the extent necessary to determine that the vessel is being maintained and operated in accordance with good marine practices and standards, and the condition of the vessel structure, equipment and systems are satisfactory for safe and constant operation.

c) Main Engine Gauges - Inboard or Inboard Outboard

1) On vessels designed for inboard or inboard/outboard (sterndrive) main engines, both of the following gauges shall be present.

A) A gauge to indicate main engine cooling water temperature for each main engine. A gauge shall be readable from each helm position.

B) A gauge to indicate main engine lubrication oil pressure for each main engine. A gauge shall be readable from each helm position.

2) All gauges installed on a vessel shall be in good and serviceable condition.

d) Personal Flotation Devices

1) At least one Coast Guard approved, wearable type personal

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flotation device of a proper size for each person, including the crew, shall be provided and carried onboard. Each device shall be inspected at the dockside inspection.

2) Each wearable type personal flotation device carried aboard the vessel shall have affixed to it, in a suitable manner, 200 square centimeters (31.5 sq. in.) of Coast Guard approved retro-reflective material to the outside of each device and 200 square centimeters (31.5 sq. in.) to the inside of each device.

3) Personal flotation devices shall be carried in suitable locations which are readily accessible to the passengers onboard. The locations shall be designed to allow the devices carried to float free when practical.

4) When personal flotation devices are carried so that they are readily accessible, but not readily visible to the passengers, the container shall be marked "LIFE PRESERVERS" and the number of devices contained therein shall be listed. The letters and numbers shall be at least 1 inch high and shall be a color contrasting to the color of the container. The container shall also indicate the size of the devices contained therein. Differing sizes shall be separately stored.

5) On documented watercraft, all required personal flotation devices shall be marked with the vessel's name in characters at least 1 inch high in a color contrasting to the color of the device.

6) On undocumented watercraft, all required personal flotation devices shall be marked with the watercraft's registration number in characters at least 1 inch high in a color contrasting to the color of the device.

7) Aboard each watercraft shall be a Type IV personal flotation device, which shall comply with all of the following requirements:

A) Be readily accessible in a suitable location.

B) Have attached not less than 50 feet of line.

C) Be marked as required by subsections (d)(5) and (d)(6) of this Section.

8) When the inspector determines that any personal flotation device required to be carried on board a vessel is not in good and serviceable condition, the owner of the vessel shall permit the marine inspector to note, in writing, on the personal flotation device that the device is no longer serviceable. The owner of the vessel shall replace the non-serviceable devices immediately and such defective devices shall be replaced prior to further use of the vessel.

e) Fire Fighting Equipment

1) A vessel shall be equipped with a U.S. Coast Guard approved portable fire extinguisher which shall be located accessible to helmsman's position.

2) All fire extinguishers shall be examined monthly to make certain that they have not been tampered with and have not suffered

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corrosion or damage.

3) All foam extinguishers shall be discharged, cleaned, and inspected for mechanical defects or serious corrosion and recharged annually.

4) All dry chemical extinguishers shall be kept full with the specified weight of chemical at all times. The cartridge shall be reweighed annually. It shall be recharged if the cartridge is found to weigh less than the minimum weight stamped thereon, or when the pressure is below prescribed operating limits.

5) All carbon dioxide extinguishers shall be reweighed annually, and a cylinder found lighter than the weight indicated on the name plate shall be recharged.

6) Maintenance required in subsections (d)(2) through (5) shall be performed by a qualified fire fighting equipment repair service.

f) First Aid Kit and Emergency Procedures List

1) A minimum of one first aid kit containing at least 16 units shall be provided and maintained onboard the watercraft.

2) An emergency procedures list shall be posted aboard the vessel in a conspicuous location. The list shall set forth, at a minimum, all of the following informational items:

A) Radio Procedure (if a marine radio is required under subsection (i))

i) Switch to Channel 16;

ii) Call the Coast Guard;

iii) Give boat name, registration number, radio call sign;

iv) Identify the boat size, description, and color;

v) Give your location or compass heading to a known point; and

vi) Describe the emergency.

B) Leaks or Damage Control

i) Put on life jackets (PFD), open deck hatches, look for leaks;

ii) Start bilge pump, get manual pumps or buckets;

iii) Shut off engine only if leak may be from engine hoses;

iv) If hull is damaged and engine is inboard (not stern drive), shut off engine, close sea cock, disconnect intake water hose, place end in bilge, restart engine to act as bilge pump.

C) Fire or Explosion

i) Be ready to go overboard with personal flotation device (life jacket);

ii) Reduce air to fire area - leave hatches closed, close doors, shut off electric supply;

iii) Use extinguisher, if possible;

iv) Jettison burning material, if possible;

v) Use radio procedure above, calling "MAYDAY, MAYDAY, MAYDAY";

vi) Prepare to abandon ship, get signal flares or flags,

throw flotation material overboard;

vii) If you abandon ship, stay together, use distress signals when help is in sight, gather additional flotation material around you.

D) Man Overboard

i) Shout "MAN OVERBOARD" - continuously watch person in the water, point direction so skipper can maneuver to retrieve;

ii) Stop engine (propeller rotation) if person overboard is near the boat;

iii) Throw life ring, seat cushion, or marker light in the area of the person;

iv) Do not jump into the water to assist.

g) Visual Distress Signals

1) A vessel which operates on navigable waters of this State, Carlyle Lake, Lake Shelbyville, or Rend Lake shall have onboard the appropriate number and type of U.S. Coast Guard approved visual distress signals as are required for that vessel if it were operated on Lake Michigan.

2) All pyrotechnic aerial red flares and pyrotechnic hand-held or floating orange smoke shall be U.S. Coast Guard approved and shall not have passed the expiration date printed on the device.

3) A person shall not display a visual distress signal on the waters of the State, except in an emergency.

4) A vessel shall have onboard at least one portable battery-operated light (flashlight), powered by D-cells or larger size batteries, which is in good and serviceable condition and readily accessible.

h) Cooking and Heating Appliances

1) Cooking appliances aboard a watercraft shall be operated only by the owner, the operator, or a crew member.

2) Cooking and heating appliances, when present on a watercraft, shall be of a type commonly manufactured for use aboard watercraft.

3) Cooking and heating appliances, when present on a watercraft, shall be installed in adequately ventilated areas and shall be secured to the vessel.

i) Marine Radio and Compass

1) A vessel which operates on the navigable waters of this State shall have onboard a marine band radio which is in good working condition, and shall be in possession of a valid Federal Communications Commission radio license for that vessel.

2) A vessel which operates on the navigable waters of this State shall have onboard a suitable marine-type compass which is in good and serviceable condition.

j) Toilet and Sanitary Facilities

1) All watercraft, except open boats and watercraft where suitable privacy enclosures are not practical, shall be equipped with one

marine toilet. The toilet shall be connected to a permanently installed holding tank, which allows for dockside pumpout at approved sanitary disposal facilities.

2) The use of Y valves or other means which would allow for overboard discharge directly or indirectly into the waters of the State is prohibited.

3) Marine toilets shall be maintained in a serviceable and sanitary condition.

k) Anchor and Anchor Line

1) A vessel shall be equipped with one anchor of a suitable size and type, and an appropriate length of suitable anchor line which is readily available onboard the vessel, except that a vessel operating on the waters of Lake Michigan shall be equipped with not less than 150 feet of suitable anchor line.

2) Any line, when attached to the required anchor, shall be attached by eyesplice, thimble, and shackle.

l) Inspection Procedures for Watercraft Carrying Not More Than Six Passengers, as defined by the United States Coast Guard

The owner of a vessel shall, at the dockside inspection, submit his vessel for inspection by an independent certifier and shall operate or cause to be operated all equipment and systems to the extent necessary to determine that the vessel is in compliance with subsections (d) through (k).

m) Inspection Exemption

Watercraft registered in another state which have been inspected under similar provisions in that state shall not be required to be inspected under the provisions of this Section.

Section 2080.60 Licensing Requirements

a) Navigable Waters (U.S. Coast Guard License)

1) All persons operating watercraft carrying passengers on the navigable waters of this State shall have a license issued to them by the United States Coast Guard authorizing the operation of navigation of vessels carrying passengers for hire, under the provisions of 46 CFR Subchapters T, K, K', and H.

2) Licensed operators shall only be authorized to operate vessels designated by the license, and on bodies of water so designated on the license.

3) The license shall be kept in full force and effect and conspicuously displayed and shall be framed under transparent material. Where posting is impractical, the certificate shall be carried onboard to be shown on demand.

b) Inland Waters

No U.S. Coast Guard license, as described in subsection (a), shall be required for watercraft operating solely on inland waters.

Section 2080.70 Certification

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a) Upon satisfactory completion of the required dry dock and annual dockside inspections, the owner shall forward to the Department the original marine inspection report on the form provided by the Department, along with an application for a "Passengers for Hire" license. The Department shall issue a "Passengers for Hire" license which shall expire on May 31 of the following year, except that the Department may extend the expiration date for a period not to exceed 30 days when extreme weather conditions exist.

b) The "Passengers for Hire" license shall be framed under transparent material and posted in a conspicuous place on the vessel. Where posting is impractical, the certificate shall be kept onboard to be shown on demand.

c) The Department shall issue one expiration validation decal with each certificate. The decal shall be prominantly diplayed upon the side of the watercraft as close to the operators' position as possible, per instructions provided by the Department.

Section 2080.80 Misuse of License or Certificate

No person shall loan, borrow, transfer or otherwise falsify any license or certificate issued by the State of Illinois or the United States Coast Guard.

Section 2080.90 Suspension and Revocation of Certificates and Licenses

a) Violations of any provisions of this Part may result in suspension of any certificate or license issued by the Department under the provisions of this Part for a period not to exceed one year.

b) Subsequent violations of any provisions of this Part within a two-year period shall result in revocation of any certificate or license issued by the Department under the provisions of this Part for a period not less than 5 years.

c) Violations of any other provisions of the Boat Registration and Safety Act [625 ILCS 45], the Fish and Aquatic Life Code [515 ILCS 5], or the Wildlife Code [520 ILCS 5] may also result in suspension or revocation of any certificate or license issued by the Department under the provisions of this Part.

d) The procedure by which suspensions and revocations are made, the rights of licensees to notice and hearing, and the procedures governing such hearings are set forth in 17 Ill. Adm. Code 2530 (Rules Governing Department Formal Hearings Conducted for Rule-Making and Contested Cases).

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Requirements for New Steel and Foundry Industry Wastes Landfills

2) Code Citation: 35 Ill. Adm. Code 817

3) Section Numbers: 817.309 — Proposed Action: Amended

4) Statutory Authority: Implementing Sections 5, 21, 21.1, 22, 22.17, 28.1, and authorized by Section 27 of the Environmental Protection Act [415 ILCS 5/5, 21, 21.1, 22, 22.17, 28.1, and 27].

5) A Complete Description of the Subjects and Issues Involved: A more detailed description is contained in the Board's Proposed Opinion of August 15, 1995, in R96-1, which is available from the Board at the address specified in question #11 below. This rule was proposed by the Illinois Cast Metal Association and requests that the Board's landfill regulations governing steel and foundry industry wastes be amended at 35 Ill. Adm. Code 817.309. Specifically, Section 817.309 establishes minimum setback distances and strata thicknesses between the waste unit and Class I and Class III groundwaters. The proposed amendments would allow the owner or operator to make a demonstration to the Illinois Environmental Protection Agency that, the absence of natural barriers notwithstanding, the unit could be operated in a manner protective of human health and the environment.

6) Will this rulemaking replace any emergency rulemaking currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending on this Part? No

10) Statement of Statewide Policy Objectives: This proposed amendment does not create or enlarge a State mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805 3].

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: This Board will accept written public comment on this proposal for a period of 45 days after the date of this publication. Comments should reference Docket R96-3 and be addressed to:

Dorothy M. Gunn, Clerk
James R. Thompson Center
Illinois Pollution Control Board
100 W. Randolph Street, Suite 11-500

POLLUTION CONTROL BOARD

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Chicago, IL 60601
(312) 814-6931

Questions may be directed to Audry Lozuk-Lawless at the Illinois Pollution Control Board at (815) 753-0947 or (312) 814-6923.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Small business owners will not be affected, this amendment concerns owners and operators of steel and foundry industry landfills.

B) Reporting, bookkeeping or other procedures required for compliance: This amendment will not change the current compliance procedures.

C) Types of professional skills necessary for compliance: The same professional skills as are currently necessary for compliance.

13) Regulatory Agenda on which this rulemaking was summarized: This rule was not included on either of the 2 most recent agendas because: This rulemaking was not anticipated at the time of the last regulatory agenda.

The full text of the Proposed Amendment begins on the next page:

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TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE G: WASTE DISPOSAL
CHAPTER I: POLLUTION CONTROL BOARD
SUBCHAPTER i: SOLID WASTE AND SPECIAL WASTE HAULING

PART 817
REQUIREMENTS FOR NEW STEEL AND FOUNDRY INDUSTRY WASTES LANDFILLS

SUBPART A: GENERAL REQUIREMENTS

Section
817.101 Scope and Applicability
817.103 Determination of Waste Status
817.104 Sampling Frequency
817.105 Waste Classification
817.106 Waste Classification Limits
817.107 Waste Mining

SUBPART B: STANDARDS FOR MANAGEMENT OF BENEFICIALLY USABLE STEEL AND FOUNDRY INDUSTRY WASTES

Section
817.201 Scope and Applicability
817.202 Limitations on Use
817.203 Notification
817.204 Long-Term Storage

SUBPART C: STEEL AND FOUNDRY INDUSTRY POTENTIALLY USABLE WASTE LANDFILLS

Section
817.301 Scope and Applicability
817.302 Design Period
817.303 Final Cover
817.304 Final Slope and Stabilization
817.305 Leachate Sampling
817.306 Load Checking
817.309 Facility Location

SUBPART D: NEW STEEL AND FOUNDRY INDUSTRY LOW RISK WASTE LANDFILLS

Section
817.401 Scope and Applicability
817.402 Facility Location
817.403 Design Period
817.404 Foundation and Mass Stability Analysis

SUBPART E: CONSTRUCTION QUALITY ASSURANCE PROGRAMS

AUTHORITY: Implementing Sections 5, 21, 21.1, 22, 22.17 and 28.1, and authorized by Section 27, of the Environmental Protection Act [415 ILCS 5/5, 21, 21.1, 22, 22.17, 28.1 and 27].

SOURCE: Adopted in R90-26(A) at 18 Ill. Reg. 12411, effective August 1, 1994; amended in R90-26(B) at 18 Ill. Reg. 14370, effective September 13, 1994; amended in R96-3 at 20 Ill. Reg. _____, effective _____.

SUBPART C: STEEL AND FOUNDRY INDUSTRY POTENTIALLY USABLE WASTE LANDFILLS

Section 817.309 Facility Location

a) No part of a unit shall be located within a setback zone established pursuant to Section 14.2 or 14.3 of the Act.

b) No part of a unit shall be located within the recharge zone or within 366 meters (1200 feet), vertically or horizontally, of that portion of a stratigraphic unit containing Class I or Class III groundwater as defined at 35 Ill. Adm. Code 620, unless:

1) There there is a stratum between the bottom of the waste disposal unit and the top of the Class I and II groundwater that meets the following minimum requirements:

A)~~1~~) The stratum has a minimum thickness of 15.2 meters (50 feet);

B)~~2~~) The maximum hydraulic conductivity in both the horizontal

and vertical directions is no more than 1 x 10(-7) centimeters per second, as determined by in situ borehole or equivalent tests;

C)~~3~~) There is no indication of continuous sand or silt seams, faults, fractures or cracks within the stratum that may provide paths pares for migration; and

D)~~4~~) Age dating of extracted water samples from both the aquifer and the stratum indicates that the time of travel for water percolating downward through the relatively impermeable stratum is no faster than 15.2 meters (50 feet) in 100 years; or

2) The owner or operator of the unit has demonstrated to the Agency, through the use of a site-specific groundwater model developed and evaluated by a qualified geologist, or through other appropriate means prepared by a qualified geologist, such as historical knowledge of local conditions or regional geological and hydrogeological data, that operation of the unit will not adversely impact any existing Class III groundwater or impact any Class I groundwater such that treatment or further treatment will be required to allow reasonable use of such Class I groundwater for potable water supply purposes.

A) Factors to be considered in evaluating whether a Class I groundwater may be reasonably used for potable supply purposes include, but are not limited to:

i) Physical or technological practicability of development;

ii) Existence of deed restrictions or other legal mechanisms for imposing a restriction on land use; and

iii) The nature of an existing use of the groundwater.

B) In performing groundwater modeling, the owner or operator shall:

i) Estimate the amount of seepage from the unit during operations assuming that the actual design standards for the unit apply;

ii) Determine the concentration of constituents in the leachate from actual leachate samples from the waste or similar waste, or laboratory-derived extracts;

iii) Collect information to develop the site-specific groundwater model e.g., hydraulic conductivity, gradients, hydrogeology, stratigraphy);

iv) Develop a conceptual groundwater flow model of the site to determine the soil units through which leachate may migrate;

v) If leachate from the unit is expected to contain organic constituents in excess of the MALCs for beneficial usable waste, determine the organic carbon content for soil units through which the leachate constituents may migrate; and

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vi) Determine the retardation factor for constituents of interest based on traditional hydrogeological methods.

c) Subsection (b) shall not apply to units that accept only beneficially useable waste.

d) A facility located within 152 meters (500 feet) of the right of way of a township or county road or State or interstate highway shall have its operations screened from view by a barrier of natural objects, fences, barricades or plants no less than 2.44 meters (8 feet) in height.

e) No part of a unit shall be located closer than 152 meters (500 feet) from an occupied dwelling, school or hospital that was occupied on the date when the operator first applied for a permit to develop the unit or the facility containing the unit, unless the owner of such dwelling, school or hospital provides permission to the operator, in writing, for a closer distance.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Aid to Families with Dependent Children

2) Code Citation: 89 Ill. Adm. Code 112

3) Section Numbers: 112.71 — Proposed Action: Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and P.A. 89-6 [305 ILCS 5/4-1.9].

5) Complete Description of the Subjects and Issues Involved: In accordance with provisions of Public Act 89-6, these proposed amendments codify a change in AFDC JOBS policy as part of the Governor's Fast Track Welfare Reform plan intended to move AFDC clients more quickly from welfare to work. Due to a change in State law and receipt of a federal waiver, this rulemaking adds the provision that parents under age 18, who are attending high school, are no longer exempt from JOBS participation. Until now, parents age 16 to 18 who were attending school full-time were exempt from participating in the Teen Parent Initiative Young Parent Services (TPI/YPS) program, a part of AFDC JOBS. These individuals could volunteer for the program, but could not be required to participate.

As a result of these proposed amendments, the following individuals, age 16 through 18 in full-time elementary, secondary or equivalent vocational/technical school, will not be exempt from JOBS participation:

1. children who return to school after becoming nonexempt;

2. children who are required to participate in the Youth Employment and Training Initiative (see 89 Ill. Adm. Code 170.10); and

3. parents under age 18 who have not completed high school or the equivalent.

These individuals must now participate in TPI/YPS unless they qualify for a different exemption. This rulemaking affects both young parents who have their own grants and those who are included in someone else's grant.

In addition, these proposed amendments establish that an individual shall be exempt from JOBS participation when the individual is the parent or other caretaker relative of a child under age three in the home. However, pursuant to the terms and conditions of the federal waiver, parents of children born under the Family Accountability provisions are not exempt from JOBS due to the care of a child under age three. Specifically, an individual cannot be exempted from JOBS participation due to providing care for a child under age three who, according to the Family Accountability Project, is included in the grant as a capped child (that is, subject to the Personal Responsibility Project as described in 89 Ill.

DEPARTMENT OF PUBLIC AID

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Adm. Code 112.251 through 112.254 and 170.350).

These proposed amendments replace amendments which were previously published on February 23, 1996 at 20 Ill. Reg. 3461. A Notice of Withdrawal, for these previously proposed amendments, was published on July 26, 1996 at 20 Ill. Reg. 10235.

6) Will these proposed amendments replace emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

Section Numbers	Proposed Action	Illinois Register Citation
112.66	New Section	August 16, 1996 (20 Ill. Reg. 10766)
112.98	Amendment	April 26, 1996 (20 Ill. Reg. 5965)
112.110	Amendment	June 28, 1996 (20 Ill. Reg. 8433)
112.151	Amendment	June 28, 1996 (20 Ill. Reg. 8433)
112.330	Amendment	August 23, 1996 (20 Ill. Reg. 11462)

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Judy Umunna
Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Ave. E., 3rd Floor
Springfield, IL 62762
(217) 524-0081

The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

The Department is unaware of any effect this rulemaking may have on small businesses, small municipalities or not-for-profit corporations. The Department will accept and consider any written comments concerning such

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effects that may be submitted in response to these proposed amendments. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory agenda on which this rulemaking was summarized: July 1996

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 112
AID TO FAMILIES WITH DEPENDENT CHILDREN

SUBPART A: GENERAL PROVISIONS

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112.1 Description of the Assistance Program
112.5 Incorporation by Reference

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

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112.8 Caretaker Relative
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112.10 Citizenship
112.20 Residence
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112.40 Relationship
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112.54 Assignment of Medical Support Rights
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112.70 Participation Requirements for JOBS
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112.77 Conciliation and Fair Hearings
112.78 JOBS Components
112.79 JOBS Sanctions
112.80 Good Cause for Failure to Comply with JOBS Participation Requirements
112.81 Responsible Relative Eligibility for JOBS
112.82 JOBS Supportive Services

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112.83 Young Parents Program
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112.87 Project Advance Experimental and Control Groups
112.88 Project Advance Participation Requirements of Experimental Group Members and Adjudicated Fathers
112.89 Project Advance Cooperation Requirements of Experimental Group Members and Adjudicated Fathers
112.90 Project Advance Sanctions
112.91 Good Cause for Failure to Comply with Project Advance
112.93 Individuals Exempt From Project Advance
112.95 Project Advance Supportive Services

SUBPART F: EXCHANGE PROGRAM

Section
112.98 Exchange Program

SUBPART G: FINANCIAL FACTORS OF ELIGIBILITY

Section
112.100 Unearned Income
112.101 Unearned Income of Stepparent or Parent
112.105 Budgeting Unearned Income
112.106 Budgeting Unearned Income of Applicants Employed On Date of Application And/Or Date Of Decision
112.107 Initial Receipt of Unearned Income
112.108 Termination of Unearned Income
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112.115 Education Benefits
112.120 Incentive Allowances
112.125 Unearned Income In-Kind
112.126 Earmarked Income
112.127 Lump Sum Payments
112.128 Protected Income
112.130 Earned Income
112.131 Earned Income Tax Credit
112.132 Budgeting Earned Income
112.133 Budgeting Earned Income of Applicants Employed On Date of Application And/Or Date Of Decision
112.134 Initial Employment
112.135 Budgeting Earned Income For Contractual Employees
112.136 Budgeting Earned Income For Non-Contractual School Employees

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SUBPART H: PAYMENT AMOUNTS

SUBPART I: OTHER PROVISIONS

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SUBPART J: CHILD CARE

SUBPART K: TRANSITIONAL CHILD CARE

AUTHORITY: Implementing Article IV and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Art. IV and 12-13].

SOURCE: Filed effective December 30, 1977; peremptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; peremptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; peremptory amendment at 2 Ill. Reg. 46, p. 56, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 3, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 82, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 199, effective August 10, 1979; amendment at 3 Ill. Reg. 33, p. 415, effective August 13, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; peremptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 2, effective November 15, 1979; peremptory

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amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 16, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7124, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; peremptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1, 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; peremptory amendment at 6 Ill. Reg. 511, effective January 1, 1982; amended at 6 Ill. Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg. 2447, effective March 1, 1982, for a maximum of 150 days; peremptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; peremptory amendment at 6 Ill. Reg. 6475, effective May 28, 1982; peremptory amendment at 6 Ill. Reg. 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299, effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; rules repealed, new rules adopted and codified at 7 Ill. Reg. 997, effective January 11, 1983; rules repealed and new rules adopted and codified at 7 Ill. Reg. 2720, effective February 28, 1983; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 3135; amended at 7 Ill. Reg. 11284, effective August 26, 1983; amended at 7 Ill. Reg. 11920, effective October 7, 1983; amended at 7 Ill. Reg. 15690, effective November 9, 1983; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 16105; amended at 7 Ill. Reg. 17344, effective December 21, 1983; amended at 8 Ill. Reg. 113, effective December 27, 1983; emergency amendment at 8 Ill. Reg. 569, effective January 1, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 4176, effective March 19, 1984; amended at 8 Ill. Reg. 5207, effective April 9, 1984; amended at 8 Ill. Reg. 7226, effective May 16, 1984; amended at 8 Ill. Reg. 11391, effective June 27, 1984; amended at 8 Ill. Reg. 12333, effective June 29, 1984; amended (by adding

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Sections being codified with no substantive change) at 8 Ill. Reg. 17894; peremptory amendment at 8 Ill. Reg. 18127, effective October 1, 1984; peremptory amendment at 8 Ill. Reg. 19889, effective October 1, 1984; amended at 8 Ill. Reg. 19983, effective October 3, 1984; emergency amendment at 8 Ill. Reg. 21666, effective October 19, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21621, effective October 23, 1984; amended at 8 Ill. Reg. 25023, effective December 19, 1984; amended at 9 Ill. Reg. 282, effective January 1, 1985; amended at 9 Ill. Reg. 4062, effective March 15, 1985; amended at 9 Ill. Reg. 8155, effective May 17, 1985; emergency amendment at 9 Ill. Reg. 10094, effective June 19, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11317, effective July 5, 1985; amended at 9 Ill. Reg. 12795, effective August 9, 1985; amended at 9 Ill. Reg. 15887, effective October 4, 1985; amended at 9 Ill. Reg. 16277, effective October 11, 1985; amended at 9 Ill. Reg. 17827, effective November 18, 1985; emergency amendment at 10 Ill. Reg. 354, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 1172, effective January 10, 1986; amended at 10 Ill. Reg. 3641, effective January 30, 1986; amended at 10 Ill. Reg. 4885, effective March 7, 1986; amended at 10 Ill. Reg. 8118, effective May 1, 1986; amended at 10 Ill. Reg. 10628, effective June 1, 1986; amended at 10 Ill. Reg. 11017, effective June 6, 1986; Sections 112.78 through 112.86 and 112.88 recodified to 89 Ill. Adm. Code 160 at 10 Ill. Reg. 11928; emergency amendment at 10 Ill. Reg. 12107, effective July 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 12650, effective July 14, 1986; amended at 10 Ill. Reg. 14811, effective August 29, 1986; amended at 10 Ill. Reg. 15101, effective September 5, 1986; amended at 10 Ill. Reg. 15621, effective September 19, 1986; amended at 10 Ill. Reg. 21860, effective December 12, 1986; amended at 11 Ill. Reg. 2280, effective January 16, 1987; amended at 11 Ill. Reg. 3140, effective January 30, 1987; amended at 11 Ill. Reg. 4682, effective March 6, 1987; amended at 11 Ill. Reg. 5223, effective March 11, 1987; amended at 11 Ill. Reg. 6228, effective March 20, 1987; amended at 11 Ill. Reg. 9327, effective May 15, 1987; amended at 11 Ill. Reg. 12003, effective November 1, 1987; emergency amendment at 11 Ill. Reg. 12432, effective July 10, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 12908, effective July 30, 1987; emergency amendment at 11 Ill. Reg. 12935, effective August 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 13625, effective August 1, 1987; amended at 11 Ill. Reg. 14755, effective August 26, 1987; amended at 11 Ill. Reg. 18679, effective November 1, 1987; emergency amendment at 11 Ill. Reg. 18781, effective November 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20114, effective December 4, 1987; Sections 112.30 and 112.95 recodified to Sections 112.52 and 112.54 at 11 Ill. Reg. 20610; amended at 11 Ill. Reg. 20889, effective December 14, 1987; amended at 12 Ill. Reg. 844, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1329, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 2126, effective January 12, 1988; SUBPARTS C, D and E recodified to SUBPARTS G, H and I at 12 Ill. Reg. 3136; amended at 12 Ill. Reg. 3487, effective January 22, 1988; amended at 12 Ill. Reg. 6159, effective March 18, 1988; amended at 12 Ill. Reg. 6694, effective March 22, 1988; amended at 12 Ill. Reg. 7336, effective May 1, 1988; amended at 12 Ill. Reg. 7673, effective April 20, 1988; amended at 12 Ill. Reg. 9032, effective May 20, 1988; amended

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at 12 Ill. Reg. 10481, effective June 13, 1988; amended at 12 Ill. Reg. 14172, effective August 30, 1988; amended at 12 Ill. Reg. 14669, effective September 16, 1988; amended at 13 Ill. Reg. 70, effective January 1, 1989; amended at 13 Ill. Reg. 6317, effective April 14, 1989; amended at 13 Ill. Reg. 8567, effective May 22, 1989; amended at 13 Ill. Reg. 16006, effective October 6, 1989; emergency amendment at 13 Ill. Reg. 16142, effective October 2, 1989, for a maximum of 150 days; emergency expired March 1, 1990; amended at 14 Ill. Reg. 705, effective January 1, 1990; amended at 14 Ill. Reg. 3170, effective February 13, 1990; amended at 14 Ill. Reg. 3575, effective February 23, 1990; amended at 14 Ill. Reg. 6306, effective April 16, 1990; amended at 14 Ill. Reg. 10379, effective June 20, 1990; amended at 14 Ill. Reg. 13652, effective August 10, 1990; amended at 14 Ill. Reg. 14140, effective August 17, 1990; amended at 14 Ill. Reg. 16937, effective September 20, 1990; emergency amendment at 15 Ill. Reg. 338, effective January 1, 1991, for a maximum of 150 days; emergency amendment at 15 Ill. Reg. 2862, effective February 4, 1991, for a maximum of 150 days; emergency expired July 4, 1991; amended at 15 Ill. Reg. 5275, effective April 1, 1991; amended at 15 Ill. Reg. 5684, effective April 10, 1991; amended at 15 Ill. Reg. 11127, effective July 19, 1991; amended at 15 Ill. Reg. 11447, effective July 25, 1991; amended at 15 Ill. Reg. 14227, effective September 30, 1991; amended at 15 Ill. Reg. 17308, effective November 18, 1991; amended at 16 Ill. Reg. 3972, effective June 15, 1992; amended at 16 Ill. Reg. 11550, effective July 15, 1992; emergency amendment at 16 Ill. Reg. 11652, effective July 1, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 13629, effective September 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 17724, effective November 9, 1992; amended at 16 Ill. Reg. 20147, effective December 14, 1992; amended at 17 Ill. Reg. 357, effective December 24, 1992; amended at 17 Ill. Reg. 813, effective January 15, 1993; amended at 17 Ill. Reg. 2253, effective February 15, 1993; amended at 17 Ill. Reg. 4312, effective March 25, 1993; emergency amendment at 17 Ill. Reg. 6325, effective April 9, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 6792, effective April 21, 1993; amended at 17 Ill. Reg. 15017, effective September 3, 1993; amended at 17 Ill. Reg. 19156, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 19636, effective November 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 5909, effective March 31, 1994; amended at 18 Ill. Reg. 6994, effective April 27, 1994; amended at 18 Ill. Reg. 8703, effective June 1, 1994; amended at 18 Ill. Reg. 10774, effective June 27, 1994; amended at 18 Ill. Reg. 12805, effective August 5, 1994; amended at 18 Ill. Reg. 18774, effective October 27, 1994; expedited correction at 19 Ill. Reg. 198, effective October 27, 1994; amended at 19 Ill. Reg. 2945, effective February 24, 1995; amended at 19 Ill. Reg. 5609, effective March 31, 1995; amended at 19 Ill. Reg. 7883, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 10206, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 12011, effective August 7, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 12664, effective September 1, 1995; emergency amendment at 19 Ill. Reg. 15214, effective November 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15661, effective November 3, 1995; emergency amendment at 19 Ill. Reg. 15839, effective November 15, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 16295, effective December 1,

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1995, for a maximum of 150 days; amended at 20 Ill. Reg. 845, effective January 1, 1996; amended at 20 Ill. Reg. 3538, effective February 15, 1996; amended at 20 Ill. Reg. 5648, effective March 30, 1996; amended at 20 Ill. Reg. 6018, effective April 12, 1996; amended at 20 Ill. Reg. 6498, effective April 29, 1996; amended at 20 Ill. Reg. 7892, effective June 1, 1996; amended at 20 Ill. Reg. _____, effective _____.

SUBPART C: JOB OPPORTUNITIES AND BASIC SKILLS TRAINING (JOBS) PROGRAM

Section 112.71 Individuals Exempt from JOBS

a) An individual shall be exempt from JOBS participation when that individual:

1) Is a child age 16 through 18 in full-time elementary, secondary grades 9-12 or equivalent vocational-technical school attendance. This exemption does not apply to: ~~Unless the child is required to participate in the Youth Employment and Training Initiative, the individual loses this exemption because he or she is no longer in school, the exemption is no longer applicable even if the individual returns to school:~~

A) children who return to school after becoming nonexempt;

B) children who are required to participate in the Youth Employment and Training Initiative (see 89 Ill. Adm. Code 170.110); and

C) parents under age 18, except those in a control group during the Work and Responsibility Demonstration in the Auburn Park and Williamson local offices;

2) Has a temporary or chronic illness ~~Temporary and Chronic Illness~~ or injuries. ~~Injuries~~

A) Temporary Illness and Injuries

i) ~~Is temporarily ill or chronically ill~~ An individual is temporarily ill when determined by the local office, on the basis of medical evidence (for example, statement from a medical provider) or on another sound basis that the illness or injury is serious enough to temporarily prevent the individual from engaging in employment or participating in JOBS. A sound basis for exemption from JOBS on a temporary basis includes but is not limited to: the observation of a cast on a broken leg or ~~the client provides~~ information, provided by the client, of a scheduled surgery or recuperation from surgery;

ii) Minor ailments and injuries, such as colds, broken fingers or rashes are not serious enough, normally, to exempt the individual under this criterion;

B) An individual is chronically ill or incapacitated, as determined by the local office, when a physician or licensed/certified psychologist finds that a physical or

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mental impairment, either by itself or in conjunction with age or other factors, prevents the individual from engaging in employment or participating in JOBS. This may include a period of recuperation after childbirth, if prescribed by a woman's physician;

C) When an individual is determined either temporarily or chronically ill or incapacitated, the exemption shall continue until further action is taken by the Department. When the exemption is initially granted, the Department will establish a date as to when the condition warranting the exemption is expected to end or when a review of the case will be reevaluated to determine whether the exempted individual continues to be exempt under the same procedures as for the initial determination of exemption, with appropriate notice to the individual that the reevaluation is necessary;

3) Is under age 16 or is age 60 years or older unless the child is required to participate in the Youth Employment and Training Initiative or is a one pregnant or parenting individual under age 18, who is required to participate in the Adolescent Parent Program (see Section 112.73);

4) Resides in an area remote from the JOBS office or service unit so that effective participation in the program is precluded. The individual is considered remote if a round trip of more than two hours by reasonably available public or private transportation, exclusive of time necessary to transport children to and from a child care facility, would be required for a normal work or training day or if an individual has no means of transportation available;

5) Provides full-time care for another household member when the need for care is due to the person's medical condition ~~Has another household member for whom that individual must provide full-time care~~;

6) Is the parent or other caretaker relative of a child under age three in the home ~~other than a minor parent under age 18 without a high school diploma or an equivalent who is required to participate in education~~ who is personally providing care for the child.

A) Only one person in a case may be exempted exempt for this reason;

B) A parent under age 20, without a high school diploma or equivalent, cannot claim this exemption;

C) A person cannot be exempted due to providing care for a child under age three who, according to the Family Accountability Project, is included in the grant as a capped child (that is, subject to the Personal Responsibility Project as described in Sections 112.251 through 112.254 and 89 Ill. Adm. Code 170.350));

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7) ~~Employment A~~) Is employed 30 hours or more per week, ~~B~~) This exemption continues to apply if there is a temporary break in full-time employment expected to last no longer than ten work days;

8) Is in the 4th month of pregnancy or later; or

9) Is a person enrolled full-time as a VISTA volunteer under Title I of the 1973 Domestic Volunteer Services Act (42 USC 4951 et seq.).

b) Individuals who request an exemption from participation in JOBS shall do so in writing with the assistance of the JOBS worker or other Department staff, if needed, and shall receive a written notice of decision on such request within 45 days. Requests for an exemption may be made at:

1) application for assistance;
2) orientation;
3) assessment;
4) reassessment;
5) AFDC eligibility redeterminations;
6) child request; or
7) whenever information received by the Department indicates the possibility of an exemption.

c) Exempt individuals may volunteer for JOBS. However, exempt volunteers who attend the orientation meeting and become program participants by completing the Initial Assessment, development of the employability plan and assignment to a component, will be sanctioned if they thereafter do not meet program requirements, without good cause (see Section 112.79).

(Source: Amended at 20 Ill. Reg. _____, effective _____)

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NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

2) Code Citation: 89 Ill. Adm. Code 149

3) Section Numbers: 149.75 — Proposed Action: Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: Effective July 5, 1995, the Health Care Financing Administration discontinued the federal requirement for attestations for Medicare discharges. Such attestations verify the accuracy of principal and secondary diagnoses and provide certification of major procedures that have been performed. Despite the federal changes, the Department believes it is necessary to retain the use of attestations to ensure accountability relative to billed diagnoses and procedures. Further, the Bureau of Medical Quality Assurance, the Attorney General's Office and the Illinois State Police support the use of attestations because of their usefulness in pursuing fraud investigations.

These proposed amendments provide for the retention of the attestation system, but change physician attestation to coding attestation and release the attending physician from the responsibility of signing the attestation form for inpatient admissions reimbursed under the Diagnosis Related Grouping methodology. According to these proposed changes, attestation procedures will be performed by staff of the Health Information Management Department. These proposed amendments will not result in any budgetary changes.

6) Will these proposed amendments replace emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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Joanne Jones, Bureau of Rules and Regulations
Illinois Department of Public Aid,
100 South Grand Ave. E., 3rd Floor
Springfield, Illinois 62762
217/524-0081

The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Hospitals that receive payments under the Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory agenda on which this rulemaking was summarized: This rule was not included on either of the 2 most recent agendas because: This rulemaking was inadvertently omitted when the most recent regulatory agenda was published.

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149
DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

Section
149.5 Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)
149.10 Applicability of Other Provisions
149.25 General Provisions
149.50 Hospital Services Subject to and Excluded from the DRG Prospective Payment System
149.75 Conditions for Payment Under the DRG Prospective Payment System
149.100 Basic Methodology for Determining DRG Prospective Payment Rates
149.105 Payment For Outlier Cases
149.125 Special Treatment of Certain Facilities
149.140 Methodology for Determining Primary Care Access Health Care Education Payments (Repealed)
149.150 Payments to Hospitals Under the DRG Prospective Payment System
149.175 Payments to Contracting Hospitals (Repealed)
149.200 Admitting and Clinical Privileges (Repealed)
149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)
149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)
149.250 Contract Monitoring (Repealed)
149.275 Transfer of Recipients (Repealed)
149.300 Validity of Contracts (Repealed)
149.305 Termination of ICARE Contracts (Repealed)
149.325 Hospital Services Procurement Advisory Board (Repealed)

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (20 ILCS 2215/Art. III) and implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code (305 ILCS 5/Arts. III, IV, V, VI and 12-13).

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 thru 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. at 12095, effective July 15, 1988; amended at 13 Ill. Reg. 354, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill. Reg. 4826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11937, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14733, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19868, effective December 7, 1992; amended at 17 Ill. Reg. 3217, effective March 1, 1993; emergency amendment at 17 Ill. Reg. 17275, effective October 1, 1993, for

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a maximum of 150 days; amended at 18 Ill. Reg. 3378, effective February 25, 1994; amended at 19 Ill. Reg. 10674, effective July 1, 1995; amended at 20 Ill. Reg. _____, effective _____.

Section 149.75 Conditions for Payment Under the DRG Prospective Payment System

a) General Requirements
   1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.
   2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid clients, the Department may, as appropriate:
      A) Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or
      B) Terminate the hospital's Provider Agreement pursuant to 89 Ill. Adm. Code 140.16.

b) Hospital Utilization Control. Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Section 149.50(c)(1), shall be in accordance with federal regulations at 42 CFR, Ch. IV, Part 456, Subpart G (October 1, 1991).

c) Medical Review Requirements: Admissions and Quality Review
   Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:
   1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.
   2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.
   3) The validity of the hospital's diagnostic and procedural information.
   4) The completeness, adequacy and quality of the services furnished in the hospital.
   5) Other medical or other practice with respect to program participants or billing for services furnished to program participants.

d) Medical Review Requirements: DRG Validation
   1) Coding Physician attestation. Beginning with admissions on or after January 1, 1997, the Health Information Management Director

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(Medical Records) or his or her designee(s) within the Health Information Management Department ~~September 1, 1991~~, for which the discharge occurs on or after December 15, 1991, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal and diagnosis, secondary diagnoses, and names of major procedures as indicated in the medical record performed. ~~The information must be in writing in the medical record and, except as provided in subsection (d)(2) below, the physician must sign the statement.~~ Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the signature of the Health Information Management Director or his or her designee(s) within this Department: ~~physician's dated signature~~ "I certify that the ICD-9-CM coding of narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete based on the contents of the medical record, to the best of my knowledge." The ~~physician's~~ name of the person signing the attestation must be typed or clearly printed and appear on the same page as the ~~physician's~~ signature.

~~2) Alternative signature requirements. The attending physician's signature, along with the other information required in subsection (d)(1), may be provided by electronic means through a hospital data system, if the hospital's Title XVIII (Medicare) intermediary has determined that the hospital data system meets the guidelines established by the Health Care Financing Administration, U.S. Department of Health and Human Services, under the Medicare Program.~~

2) DRG Validation. The Department or its designee may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.

3) Sample Reviews

A) The Department, or its designee, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.

B) Code validation must be done on the basis of a review of medical records and, at the Department's discretion, may take place at the hospital or away from the hospital site.

4) Revision of Coding

A) If the diagnostic and procedural information, attested to by the Health Information Management Director or his or her designee(s) within the Health Information Management Department attending physician, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

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B) If the information attested to by the Health Information Management Director or his or her designee(s) within the Health Information Management Department physician as stipulated under subsection (d)(4)(A) above ~~(d)(5)(A)~~ is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

e) Medical Review Requirements: The Department, or its designee, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews of:

1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2) The quality and/or the nature of the utilization of health services.

3) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.

4) The validity of the hospital's diagnostic and procedural information.

5) The completeness, adequacy and quality of the services furnished in the hospital.

6) Other medical or other practices with respect to program participants or billing for services furnished to program participants.

f) Hospitals shall be notified at least ~~thirty (~~ 30~~)~~ days in advance of any pre-admission, concurrent, or pre-payment review requirements imposed by the Department.

g) Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

1) If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.

B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.

C) Perform prepayment review in accordance with 89 Ill. Adm. Code 148.240(c).

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2) When payment with respect to the discharge of an individual patient is denied by the Department, or its designee, under subsection (g)(1)(A) above, a reconsideration will be provided within 30 days, upon the request of a practitioner or provider, if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days after of the Advisory Notice. The date of the Advisory Notice is counted as day one.

3) A determination under subsection (g)(1) above, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in actions specified in subsection (a)(2) above.

h) Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

1) The applicable payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (h)(1)(B)(i) through (h)(1)(B)(v) below.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis

i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis

i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital

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reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a non teaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 20 Ill. Reg. _____, effective

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1) Heading of the Part: Food Stamps

2) Code Citation: 89 Ill. Adm. Code 121

3)

Section Numbers:	Proposed Action:
121.93	Amendment
121.94	Amendment
121.98	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and 7 CFR 274.12.

5) Complete Description of the Subjects and Issues Involved: Pursuant to provisions in 7 CFR 274.12, these proposed amendments implement the Electronic Benefits Transfer (EBT) system. The EBT system is a method by which cash and food stamp benefits are issued and redeemed through electronic technology. The EBT system replaces paper checks and food stamp coupons currently used to deliver benefits to clients. Benefits are electronically issued and redeemed without the creation of a paper check or food stamp coupons.

The EBT program will be used for clients who receive help in the form of food stamp coupons, grants and child support pass-through payments. Specifically, those persons in cash assistance programs such as Aid to Families with Dependent Children (AFDC), Aid to the Aged, Blind or Disabled (AABD), Refugee Repatriate Assistance (RRA), the State General Assistance program in Chicago and Child Support Enforcement pass-through payments will use the EBT system. MANG cases will not be included in EBT, unless the individuals receive food stamp benefits. Also, non-assistance/MANG child support cases will not be included in EBT.

Benefits of the EBT system include the following:

- improves the delivery of benefits to clients;
- helps reduce theft and loss;
- provides better security to reduce benefit fraud;
- eliminates check cashing fees;
- reduces administrative and operating costs; and
- reduces the stigma attached to cashing benefit checks and using food stamp coupons.

The EBT system being developed by the Department will provide clients with a plastic card, similar to a bank card, to be used at Point-of Sale (POS) terminals and Automated Teller Machines (ATMs). The individual will select a confidential, four-digit code that will enable him or her to access his or her benefits through POS terminals or ATMs. Clients will use their cards to draw against their food stamp benefits and cash assistance accounts.

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The EBT process will work like standard POS/ATM withdrawals, only the money will come from a public aid account instead of a bank account. Computer terminals will display account balances and print receipts showing available funds or food stamp credits. Food stamp and other electronic accounts, maintained by the State, will be debited automatically. Clients purchasing food will use their cards in grocery stores and their food stamp accounts will decrease by the amount of the food purchase. Purchases will be paid for by immediate deductions from the account.

These proposed amendments establish that clients will be trained on the use of the EBT system and EBT care prior to receipt of benefits via EBT. This rulemaking also sets out the provisions for replacement of the EBT.

Using the EBT system will provide clients with an opportunity to gain money management experience by withdrawing benefits, as needed. In addition, clients will no longer have to pay check-cashing fees each month. The delivery and management of benefits to clients will be improved by the EBT system. Administrative costs of distributing and redeeming food stamp benefits will be reduced. Also, fraud and misuse of food stamp benefits will be reduced through the EBT system. Companion amendments are being proposed in 89 Ill. Adm. Code 117.

6) Will these proposed amendments replace emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

Sections	Proposed Action	Illinois Register Citation
121.22	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.23	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.24	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.25	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.26	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.27	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.29	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.30	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.31	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.63	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.71	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.75	Amendment	August 2, 1996 (20 Ill. Reg. 10263)

10) Statement of Statewide Policy Objectives: These proposed amendments do

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not affect units of local government.

11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to Judy Umunna, Bureau of Rules and Regulations, Illinois Department of Public Aid, 100 South Grand Ave. E., 3rd Floor, Springfield, Illinois 62762 (Phone: (217) 524-0081). The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not for profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not for profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Grocery stores

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory agenda on which this rulemaking was summarized: August 1996

The full text of the Proposed Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 121
FOOD STAMPS

SUBPART A: APPLICATION PROCEDURES

Section
121.1 Application for Assistance
121.2 Time Limitations on the Disposition of an Application
121.3 Approval of an Application and Initial Authorization of Assistance
121.4 Denial of an Application
121.5 Client Cooperation
121.6 Emergency Assistance
121.7 Expedited Services
121.10 Interviews

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
121.19 Ending a Voluntary Quit Disqualification
121.20 Citizenship
121.21 Residence
121.22 Social Security Numbers
121.23 Work Registration/Participation Requirements (Repealed)
121.24 Individuals Exempt From Work Registration Requirements (Repealed)
121.25 Failure to Comply (Repealed)
121.26 Period of Disqualification (Repealed)
121.27 Voluntary Job Quit
121.28 Good Cause for Voluntary Job Quit
121.29 Exemptions from Voluntary Quit Rule

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

Section
121.30 Unearned Income
121.31 Exempt Unearned Income
121.32 Education Benefits
121.33 Unearned Income In-Kind
121.34 Lump Sum Payments and Income Tax Refunds
121.40 Earned Income
121.41 Budgeting Earned Income
121.50 Exempt Earned Income
121.51 Income from Work/Study/Training Programs
121.52 Earned Income from Roomer and Boarder

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SUBPART D: ELIGIBILITY STANDARDS

SUBPART E: HOUSEHOLD CONCEPT

SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

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SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

AUTHORITY: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13].

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SOURCE: Adopted December 30, 1977; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 31, p. 109, effective August 3, 1979; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 41, p. 165, effective October 11, 1979; amended at 3 Ill. Reg. 42, p. 230, effective October 9, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 36, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 3, p. 49, effective January 9, 1980; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 23, 1980; amended at 4 Ill. Reg. 10, p. 253, effective February 27, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 17, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1131, effective January 16, 1981; amended at 5 Ill. Reg. 4586, effective April 15, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 12736, effective October 29, 1981; amended at 6 Ill. Reg. 1653, effective January 17, 1982; amended at 6 Ill. Reg. 2707, effective March 2, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10208, effective August 9, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 5435; amended at 7 Ill. Reg. 5715, effective May 1, 1983; amended at 7 Ill. Reg. 8118, effective June 24, 1983; peremptory amendment at 7 Ill. Reg. 12899, effective October 1, 1983; amended at 7 Ill. Reg. 13655, effective October 4, 1983; peremptory amendment at 7 Ill. Reg. 16067, effective November 18, 1983; amended at 7 Ill. Reg. 16169, effective November 22, 1983; amended at 8 Ill. Reg. 5673, effective April 18, 1984; amended at 8 Ill. Reg. 7249, effective May 16, 1984; peremptory amendment at 8 Ill. Reg. 10086, effective July 1, 1984; amended at 8 Ill. Reg. 13284, effective July 16, 1984; amended at 8 Ill. Reg. 17900, effective September 14, 1984; amended (for adding Section being codified with no substantive change) at 8 Ill. Reg. 17898; peremptory amendment at 8 Ill. Reg. 19690, effective October 1, 1984; peremptory amendment at 8 Ill. Reg. 22145, effective November 1, 1984; amended at 9 Ill. Reg. 302, effective January 1, 1985; amended at 9 Ill. Reg. 6804, effective May 1, 1985; amended at 9 Ill. Reg. 8665, effective May 29, 1985; peremptory amendment at 9 Ill. Reg. 8898, effective July 1, 1985; amended at 9 Ill. Reg. 11334, effective July 3, 1985; amended at 9 Ill. Reg. 14334, effective September 6, 1985; peremptory amendment at 9 Ill. Reg. 15582, effective October 1, 1985; amended at 9 Ill. Reg. 16889, effective October 16, 1985; amended at 9 Ill. Reg. 19726, effective December 9, 1985; amended at 10 Ill. Reg. 229, effective December 20, 1985; peremptory amendment at 10 Ill. Reg. 7387, effective April 21, 1986; peremptory amendment at 10 Ill. Reg. 7941, effective May 1, 1986; amended at 10 Ill. Reg. 14692, effective August 29, 1986; peremptory amendment at 10 Ill.

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Reg. 15714, effective October 1, 1986; Sections 121.200 thru 121.208 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; peremptory amendment at 11 Ill. Reg. 3761, effective February 11, 1987; emergency amendment at 11 Ill. Reg. 3754, effective February 13, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 9968, effective May 15, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 10269, effective May 22, 1987; amended at 11 Ill. Reg. 10621, effective May 25, 1987; peremptory amendment at 11 Ill. Reg. 11391, effective July 1, 1987; peremptory amendment at 11 Ill. Reg. 11855, effective June 30, 1987; emergency amendment at 11 Ill. Reg. 12043, effective July 6, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 13635, effective August 1, 1987; amended at 11 Ill. Reg. 14022, effective August 10, 1987; emergency amendment at 11 Ill. Reg. 15261, effective September 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 15480, effective September 4, 1987; amended at 11 Ill. Reg. 15634, effective September 11, 1987; amended at 11 Ill. Reg. 18218, effective October 30, 1987; peremptory amendment at 11 Ill. Reg. 18374, effective October 30, 1987; amended at 12 Ill. Reg. 877, effective December 30, 1987; emergency amendment at 12 Ill. Reg. 1941, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 4204, effective February 5, 1988; amended at 12 Ill. Reg. 9678, effective May 23, 1988; amended at 12 Ill. Reg. 9922, effective June 1, 1988; amended at 12 Ill. Reg. 11463, effective June 30, 1988; amended at 12 Ill. Reg. 12824, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 14045, effective August 19, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 15704, effective October 1, 1988; peremptory amendment at 12 Ill. Reg. 16271, effective October 1, 1988; amended at 12 Ill. Reg. 20161, effective November 30, 1988; amended at 13 Ill. Reg. 3890, effective March 10, 1989; amended at 13 Ill. Reg. 13619, effective August 14, 1989; peremptory amendment at 13 Ill. Reg. 15859, effective October 1, 1989; amended at 14 Ill. Reg. 729, effective January 1, 1990; amended at 14 Ill. Reg. 6349, effective April 13, 1990; amended at 14 Ill. Reg. 13202, effective August 6, 1990; peremptory amendment at 14 Ill. Reg. 15158, effective October 1, 1990; amended at 14 Ill. Reg. 16983, effective September 30, 1990; amended at 15 Ill. Reg. 11150, effective July 22, 1991; amended at 15 Ill. Reg. 12957, effective August 12, 1991; peremptory amendment at 15 Ill. Reg. 14134, effective October 1, 1991; emergency amendment at 16 Ill. Reg. 767, effective January 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 10011, effective June 15, 1992; amended at 16 Ill. Reg. 13900, effective August 31, 1992; emergency amendment at 16 Ill. Reg. 16221, effective October 1, 1992, for a maximum of 150 days; peremptory amendment at 16 Ill. Reg. 16345, effective October 1, 1992; amended at 16 Ill. Reg. 16624, effective October 23, 1992; amended at 17 Ill. Reg. 644, effective December 31, 1992; amended at 17 Ill. Reg. 4333, effective March 19, 1993; amended at 17 Ill. Reg. 14625, effective August 26, 1993; emergency amendment at 17 Ill. Reg. 15149, effective September 1, 1993, for a maximum 150 days; peremptory amendment at 17 Ill. Reg. 17477, effective October 1, 1993; expedited correction at 17 Ill. Reg. 21216, effective October 1, 1993; amended at 18 Ill. Reg. 2033, effective January 21, 1994; emergency amendment at 18 Ill. Reg. 2509, effective January 27, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 3427, effective February 28, 1994; amended at 18 Ill. Reg. 8921, effective June 3, 1994;

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amended at 18 Ill. Reg. 12829, effective August 5, 1994; amended at 18 Ill. Reg. 14103, effective August 26, 1994; amended at 19 Ill. Reg. 5626, effective March 31, 1995; amended at 19 Ill. Reg. 6648, effective May 5, 1995; emergency amendment at 19 Ill. Reg. 12705, effective September 1, 1995, for a maximum of 150 days; peremptory amendment at 19 Ill. Reg. 13595, effective October 1, 1995; amended at 20 Ill. Reg. 1593, effective January 11, 1996; peremptory amendment at 20 Ill. Reg. 2229, effective January 17, 1996; amended at 20 Ill. Reg. 7902, effective June 1, 1996; amended at 20 Ill. Reg. _____, effective August 14, 1996; amended at 20 Ill. Reg. _____, effective _____.

SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

Section 121.93 ~~Direct-Mail~~ Issuance of Food Stamp Benefits ~~Coupons~~

a) In ~~participating non-urban areas~~ where the Electronic Benefits Transfer (EBT) system is not in operation, the Department will mail food stamp coupons to all households eligible to receive food stamps directly to the participant's mailing address. A household may, however, request that its ~~its~~ food stamp coupons be sent to the local office address instead of to the mailing address. Coupons mailed to the local office must be claimed by the household within five ~~(5)~~ post office working days.

b) In areas where the EBT system is operative, food stamp benefits shall be issued to the payee via an electronic benefits account established by the Department through EBT. The payee may access the benefits at any participating Point-of-Sale (POS) terminal unless an administrative remedy in Section 121.94(d) of this Part has been imposed.

c) In areas where the Department has a contract or contracts with specific Direct Delivery Agents (DDAs) and the EBT system is not operative, the food stamp benefits will be delivered to the DDA for distribution to the client. If more than one DDA is available, the client may select the DDA of his or her choice. Clients may be exempted from participation in direct delivery for specific circumstances. For example, client is in an educational or training program or employed and hours of attendance or employment prevent the client from picking up the food stamp benefits during normal business hours, client is permanently homebound and no proxy is available or client is in exempt status.)

d) If direct delivery is not available and the EBT system is not operative, the client may elect to have the food stamp benefits delivered to the local public assistance office.

~~b) When a household reports the non-receipt of coupons issued through the mail, the Department shall authorize a replacement issuance only if the coupons were validly issued, the household has not been issued more than one replacement in the previous five months and if sufficient time, up to five post office working days, has elapsed for delivery. The replacement coupons will be sent to the local office address and thereafter, for the next two months following the replacement, each month's regular issuance of coupons will be sent to the local office address.~~

~~c) Replacement coupons shall not be issued when a participant claims that the envelope received in the mail contained less than the authorized allotment unless the coupon loss was due to damage in the mail before delivery or the Direct Mail Issuance Center inventory is incorrect. Additionally, replacement coupons shall not be issued for coupons that are received but subsequently lost or misplaced.~~

(Source: Amended at 20 Ill. Reg. _____, effective _____)

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Section 121.94 Replacement of the EBT Card or ~~Food Stamp Benefits Coupons~~

a) Replacement of the EBT Card
   1) The EBT card (benefit access device) will be replaced if lost, stolen or damaged.
   2) The loss, theft or damage of the EBT card must be immediately reported to the EBT contractor.
   3) The client will go to the local public assistance office for replacement of the EBT card and selection of a Personal Identification Number (PIN).
   4) Administrative remedies, as described in subsection (d) of this Section, may be imposed following the loss, theft or damage of the EBT card or the loss of food stamp benefits.

b) For households receiving food stamp benefits via the EBT system, lost benefits resulting from the loss or theft of the EBT card and PIN will not be replaced due to the client's mismanagement or presumed fraud, collusion or cooperation.

c) For households receiving food stamp benefits via food stamp coupons not through the EBT system, the following rules will apply:
   1) When a household reports the non-receipt of coupons issued through the mail, the Department shall authorize a replacement issuance only if the coupons were validly issued, the household has not been issued more than one replacement in the previous five months and if sufficient time, up to five post office working days, has elapsed for delivery. The replacement coupons will be sent to the local office address and thereafter, for the next two months following the replacement, each month's regular issuance of coupons will be sent to the local office address.
   2) Replacement coupons shall not be issued when a participant claims that the envelope received in the mail contained less than the authorized allotment unless the coupon loss was due to damage in the mail before delivery or the Direct Mail Issuance Center inventory is incorrect. Additionally, replacement coupons shall not be issued for coupons that are received but subsequently are

lost or misplaced.

3)a~~)~~ If a household requests replacement of food stamp coupons which were received by the household but which were improperly manufactured or were subsequently damaged or mutilated, the Department shall replace the coupons in an amount equal to the value of the improperly manufactured or mutilated coupons. A coupon cannot be replaced if less than three-fifths of the coupon is presented by the household.

4)b~~)~~ If a household requests replacement of food stamp coupons which were received but subsequently destroyed in a household disaster, and the request is made within ten ~~(10)~~ days of the disaster, the Department shall replace the coupons in an amount not to exceed one month's worth of coupons within ten days after the date destruction was reported to the local office. The disaster must be verified. Replacement of destroyed coupons is limited to twice in a six-month ~~six-month~~ period.

5)c~~)~~ Replacement food stamp coupons shall not be issued for coupons that are lost, misplaced or stolen.

d) Administrative Remedies

The Department may employ any of the following administrative remedies to deter multiple claims of benefit loss or multiple EBT card replacements, subject to notice and appeal by the client:

1) Retraining - The Department may require the client to attend and participate in additional EBT training. The emphasis in the training will be to reaffirm the client's responsibility in securing the EBT card and PIN and to ensure secure and responsible participation in the EBT system.

2) Charge for Replacement Card or Cards - The Department may assess a fee for replacement of the EBT card. Such fees may increase for subsequent replacement cards.

3) Telephone Approval - The Department may require the client to obtain time and amount-limited telephonic approval for use of the EBT card. The client would be required to place a call to the EBT contractor and positively identify himself or herself. The preauthorization would be time-limited and for a specific, preauthorized amount. The client would be able to use the card for a period of two hours or for some other period designated by the Department. The amount of the transaction could not exceed the preauthorized amount and must be accomplished electronically (manual authorization or voucher processing). Key-entered transactions or exception processing may not be used.

4) Transaction Withdrawals - To assist a client in managing his or her funds or to reduce the potential for fraud, the Department may limit the amount of benefits that may be withdrawn or used per transaction per day. The amount would not exceed $50.00 and may be lowered, as determined by the Department to be necessary under the individual circumstances.

5) Use of Specific POS Terminals - The Department may notify a client that it has restricted benefit access points available to the client. The client may be restricted to accessing benefits at one or two locations, designated by the Department. The merchant or retailer would have to obtain telephone authorization of the transaction. Use of exception processing or key-entered transactions would not be allowed. This determination can only be imposed for a period not to exceed 24 months and is designed to address situations of mismanagement, fraud, multiple replacement requests and intentional program violations.

6) Use of Protective, or Alternate, Payee - Repeated loss of the EBT card and PIN is a basis for a determination of client mismanagement and authorization of a Protective Payee Plan (PPP).

e) Other Remedies

The Department may use other remedies to reduce future claims and to address fraud, abuse, collusion or intentional program violations, as warranted by the individual case circumstances. Those remedies may include, but shall not be limited to:

1) disqualification;
2) penalties, fines and/or imprisonment consistent with federal and State law and regulations; and
3) referrals to federal law enforcement authorities, when appropriate.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 121.98 Client Training for the Electronic Benefits Transfer (EBT) System ~~Food Stamp Simplified Application Demonstration Project (Repealed)~~

a) Clients will be trained on the use of the EBT system and EBT card prior to receipt of benefits via EBT.

b) Clients will be provided training and materials related, but not limited, to:

1) the appropriate use and security of the EBT card and PIN;
2) client liabilities for benefit loss;
3) information on transaction limitations and charges;
4) client responsibility for reporting loss or theft of the EBT card and to whom and how such reports should be made;
5) information on the services available from the Client Helpline Number;
6) proper care and protection of the EBT card;
7) replacement card policy; and
8) how to report problems with the EBT card or EBT system equipment.

(Source: Repealed at 10 Ill. Reg. 14692, effective August 29, 1986; new Section adopted at 20 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Related Program Provisions

2) Code Citation: 89 Ill. Adm. Code 117

3)

Section Numbers:	Proposed Action:
117.10	Amendment
117.11	New Section
117.12	New Section
117.13	New Section

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and 7 CFR 274.12.

5) Complete Description of the Subjects and Issues Involved: Pursuant to provisions in 7 CFR 274.12, these proposed amendments implement the Electronic Benefits Transfer (EBT) system. The EBT system is a method by which cash and food stamp benefits are issued and redeemed through electronic technology. The EBT system replaces paper checks and food stamp coupons currently used to deliver benefits to clients. Benefits are electronically issued and redeemed without the creation of a paper check or food stamp coupons.

The EBT program will be used for clients who receive help in the form of food stamp coupons, grants and child support pass-through payments. Specifically, those persons in cash assistance programs such as Aid to Families with Dependent Children (AFDC), Aid to the Aged, Blind or Disabled (AABD), Refugee Repatriate Assistance (RRA), the State General Assistance program in Chicago and Child Support Enforcement pass-through payments will use the EBT system. MANG cases will not be included in EBT, unless the individuals receive food stamp benefits. Also, non-assistance/MANG child support cases will not be included in EBT.

Benefits of the EBT system include the following:

- improves the delivery of benefits to clients;
- helps reduce theft and loss;
- provides better security to reduce benefit fraud;
- eliminates check cashing fees;
- reduces administrative and operating costs; and
- reduces the stigma attached to cashing benefit checks and using food stamp coupons.

The EBT system being developed by the Department will provide clients with a plastic card, similar to a bank card, to be used at Point-of-Sale (POS) terminals and Automated Teller Machines (ATMs). The individual will select a confidential, four-digit code that will enable him or her to access his or her benefits through POS terminals or ATMs. Clients will use their cards to draw against their food stamp benefits and cash assistance accounts.

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The EBT process will work like standard POS/ATM withdrawals, only the money will come from a public aid account instead of a bank account. Computer terminals will display account balances and print receipts showing available funds or food stamp credits. Food stamp and other electronic accounts, maintained by the State, will be debited automatically. Clients purchasing food will use their cards in grocery stores and their food stamp accounts will decrease by the amount of the food purchase. Purchases will be paid for by immediate deductions from the account.

These proposed amendments establish that clients will be trained on the use of the EBT system and EBT care prior to receipt of benefits via EBT. This rulemaking also sets out the provisions for replacement of the EBT card.

Using the EBT system will provide clients with an opportunity to gain money management experience by withdrawing benefits, as needed. In addition, clients will no longer have to pay check-cashing fees each month. The delivery and management of benefits to clients will be improved by the EBT system. Administrative costs of distributing and redeeming food stamp benefits will be reduced. Also, fraud and misuse of food stamp benefits will be reduced through the EBT system.

Companion amendments are being proposed in 89 Ill. Adm. Code 121.

6) Will these proposed amendments replace emergency amendments currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? Yes

Section Numbers	Proposed Action	Illinois Register Citation
117.50	Amendment	August 2, 1996 (20 Ill. Reg. 10303)

10) Statement of Statewide Policy Objectives: These proposed amendments do not affect units of local government.

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11) Time, Place, and Manner in which Interested Persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Judy Umunna
Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Ave. E., 3rd Floor
Springfield, IL 62762
(217) 524-0081

The Department requests the submission of written comments within 30 days after the publication of this notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act (5 ILCS 100/5-40).

These proposed amendments may have an impact on small businesses, small municipalities, and not for profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act (5 ILCS 100/1-75, 1-80, 1-85). These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act (5 ILCS 100/5-30). These entities shall indicate their status as small businesses, small municipalities, or not for profit corporations as part of any written comments they submit to the Department.

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Grocery stores

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

13) Regulatory agenda on which this rulemaking was summarized: July 1996

The full text of the Proposed Amendments begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER vv: DISTRICT, COUNTY, TOWNSHIP AND SPECIAL ACT (MUTUAL COMPANIES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 117
RELATED PROGRAM PROVISIONS

Section
117.1 Incorporation By Reference
117.10 Payee For Financial Assistance
117.11 Issuance of Cash Assistance Benefits
117.12 Client Training for the Electronic Benefits Transfer (EBT) System
117.13 Replacement of the EBT Card
117.15 Reinstatement Upon Agreement to Cooperate
117.20 Replacement of Missing Warrants
117.30 Withholding of Rent (Repealed)
117.40 Recovery of Interim Assistance - Aid to the Aged, Blind or Disabled and General Assistance
117.50 Funerals and Burials
117.51 Funeral Home Services
117.52 Burial Expenses
117.53 Payment to Vendor(s)
117.54 Claims for Reimbursement
117.55 Submittal of Claims
117.60 Substitute Parental Care/Supplemental Child Care - AFDC, AABD and GA Family Cases
117.70 Charge for Replacement of Photo ID Cards (Repealed)
117.80 Direct Deposit of Recipients' Warrants
117.90 State Income Tax Match

AUTHORITY: Implementing Articles III, IV and VI and authorized by Section 12-13 of the Illinois Public Aid Code (305 ILCS 5/Arts. III, IV and VI, and 12-13).

SOURCE: Filed and effective December 29, 1977; amended at 2 Ill. Reg. 31, p. 68, effective August 3, 1978; amended at 3 Ill. Reg. 38, p. 258, effective September 20, 1979; amended at 3 Ill. Reg. 41, p. 167, effective October 1, 1979; codified at 7 Ill. Reg. 5135; amended at 7 Ill. Reg. 16111, effective November 22, 1983; amended at 9 Ill. Reg. 3726, effective March 13, 1985; amended at 9 Ill. Reg. 4526, effective March 20, 1985; amended at 9 Ill. Reg. 8733, effective May 29, 1985; amended at 9 Ill. Reg. 10779, effective July 5, 1985; amended at 9 Ill. Reg. 16914, effective October 16, 1985; amended at 11 Ill. Reg. 4759, effective March 13, 1987; amended at 12 Ill. Reg. 2985, effective January 13, 1988; amended at 12 Ill. Reg. 13608, effective August 15, 1988; amended at 12 Ill. Reg. 14296, effective August 30, 1988; amended at 13 Ill. Reg. 3936, effective March 10, 1989; amended at 14 Ill. Reg. 780,

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effective January 1, 1990; amended at 14 Ill. Reg. 9488, effective June 1, 1990; amended at 15 Ill. Reg. 13533, effective August 1, 1991; amended at 16 Ill. Reg. 16644, effective October 23, 1992; emergency amendment at 17 Ill. Reg. 2368, effective February 8, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 8191, effective May 24, 1993; amended at 18 Ill. Reg. 3746, effective February 28, 1994; amended at 18 Ill. Reg. 7403, effective April 29, 1994; amended at 19 Ill. Reg. 1103, effective January 26, 1995; amended at 19 Ill. Reg. 10702, effective July 7, 1995; emergency amendment at 19 Ill. Reg. 15267, effective November 1, 1995, for a maximum of 150 days; amended at 20 Ill. Reg. 877, effective January 1, 1996; amended at 20 Ill. Reg. 5706, effective March 30, 1996; emergency amendment at 20 Ill. Reg. 10381, effective July 23, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. _____, effective _____.

Section 117.10 Payee For Financial Assistance

a) The assistance grant shall be paid to an individual designated as the payee on the warrant or the individual authorized to use the Electronic Benefits Transfer (EBT) card or, for direct deposit accounts, the person in whose name the bank account is established.

b) The individual receiving assistance shall be designated as the payee with the following exceptions:

1) When a client has a judicially appointed conservator or guardian, payment shall be made to the conservator or guardian unless other arrangements are made with the Department by the conservator or guardian.

2) In situation where no specified relative is available to act as payee, another person may act as Temporary Grantee for a period not to exceed 90 days.

3) A Protective Payment Plan ~~protective payment plan~~ (PPP) is initiated by the Department when a client has demonstrated mismanagement of funds to the detriment of the welfare of the client or family. Examples include but are not limited to:

A) A client defaults on an agreement made with a utility company and the Department in the client's behalf. In this instance, when the protective payee receives the assistance payment, payment on current and back utility charges only shall be paid by the payee; the balance of the payment shall be forwarded to the client each month.

B) For AFDC only - When a child in the assistance unit is determined to be neglected by the Department of Children and Family Services under Section 3 of the Abused and Neglected Child Reporting Act [325 ILCS 5/3] and 89 Ill. Adm. Code 300.Appendix B.

C) For AFDC only - The case involves a record establishing that a parent or relative has been found guilty of public assistance fraud under Article VIII A of the Illinois Public Aid Code [305 ILCS 5/Art. VIII A].

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D) Nonpayment of rent for two months shall be considered as evidence of grant mismanagement.

E) Substance abuse by the caretaker relative is identified and another family member or friend is ensuring that the family's needs are being met.

F) For AFDC only - the health and well-being of a child in the assistance unit is at risk, as indicated by lack of regular school attendance, as defined by the school.

G) Repeated loss of both the EBT card and Personal Identification Number (PIN) is a basis for determination of client mismanagement and authorization of a Protective Payment Plan (PPP).

c) Notice shall be sent to the client before a protective payment plan is initiated. The notice shall inform the client of the right to appeal inclusion in a protective payment plan. (See 89 Ill. Adm. Code 104.)

d) The protective payee shall not receive compensation for the protective payee duties and must agree to assume responsibility for the expenditure of the assistance payment in behalf of the client.

e) The client's landlord or a vendor of goods or services to the client, with the exception of private welfare and social service agencies, shall not be designated as protective payee.

f) The Department may designate private welfare or social service agencies to serve as protective payees.

g) When no other suitable payee is available, the Department may appoint a member of its staff to act as protective payee. However, the staff acting as protective payee may not be:

1) a person determining the client's eligibility or level of assistance;

2) a person handling fiscal processing relating to the recipient;

3) investigative staff; or

4) a local office administrator.

h) The need for continuation of a protective payment plan and the performance of the protective payee shall be reviewed and evaluated by the Department as often as circumstances indicate, or, for AFDC cases at least every 12 months.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 117.11 Issuance of Cash Assistance Benefits

a) In areas where the Electronic Benefits Transfer (EBT) system is operative, cash assistance benefits shall be issued to the payee via an electronic benefits payment file established by the Department through EBT. The payee may access the cash benefits at any participating Point-of-Sale (POS) terminal or Automated Teller Machine (ATM). Clients may elect to use a direct deposit account in an EBT area to receive cash assistance benefits but may not elect any other

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delivery option.

b) In areas where the Department has a contract or contracts with specific Direct Delivery Agents (DDAs) and the EBT system is not operative, the cash assistance benefits will be delivered to the DDA for distribution to the client. If more than one DDA is available, the client may select the DDA of his or her choice. Clients may be exempted from participation in direct delivery for specific circumstances. For example, client is in an educational or training program or employed and hours of attendance or employment prevent the client from picking up the warrant during normal business hours, client is permanently homebound and no proxy is available or client is in exempt status.)

c) If the client has a checking or savings account, the client may elect to have cash assistance benefits delivered via direct deposit to the financial institution where the client account resides.

d) In circumstances where none of the above delivery options are available, a warrant for the cash assistance benefits will be delivered to the client's residence or other secure address, as selected by the client.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 117.12 Client Training for the Electronic Benefits Transfer (EBT) System

a) Clients will be trained on the use of the EBT system and EBT card prior to receipt of benefits via EBT.

b) Clients will be provided training and materials related, but not limited to:

1) the appropriate use and security of the EBT card and Personal Identification Number (PIN);
2) client liabilities for benefit loss;
3) information on transaction limitations and charges;
4) client responsibility for reporting loss or theft of the EBT card and to whom and how such reports should be made;
5) information on the services available from the Client Helpline Number;
6) proper care and protection of the EBT card;
7) replacement card policy; and
8) how to report problems with the EBT card or EBT system equipment.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 117.13 Replacement of the EBT Card

a) Replacement of the EBT Card

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1) The EBT card (benefit access device) will be replaced if lost, stolen or damaged.
2) The loss, theft or damage of the EBT card must be immediately reported to the EBT contractor.
3) The client will go to the local public assistance office for replacement of the EBT card and selection of a new Personal Identification Number (PIN).
4) Administrative remedies, as described in subsection (b) of this Section, may be imposed following the loss, theft or damage of the EBT card or the loss of assistance benefits.

b) Administrative Remedies

The Department may employ any of the following administrative remedies to deter multiple claims of benefit loss or multiple EBT card replacements, subject to notice and appeal by the client:

1) Retraining - The Department may require the client to attend and participate in additional EBT training. The emphasis in the training will be to reaffirm the client's responsibility in securing the EBT card and PIN and to ensure secure and responsible participation in the EBT system.
2) Charge for Replacement Card or Cards - The Department may assess a fee for replacement of the EBT card. Such fees may increase for subsequent replacement cards.
3) Telephone Approval - The Department may require the client to obtain time and amount-limited telephonic approval for use of the EBT card. The client would be required to place a call to the EBT contractor and positively identify himself or herself. The preauthorization would be time-limited and for a specific, preauthorized amount. The client would be able to use the card for a period of two hours or for some other time period designated by the Department. The amount of the transaction could not exceed the preauthorized amount and must be accomplished electronically - manual authorization or voucher processing). Key-entered transactions or exception processing may not be used.
4) Transaction Withdrawals - To assist a client in managing his or her funds or to reduce the potential for fraud, the Department may limit the amount of benefits that may be withdrawn or used per transaction per day. The amount would not exceed $50.00 and may be lowered, as determined by the Department to be necessary under the individual circumstances.
5) Use of Specific Point-of-Sale (POS) Terminals - The Department may notify a client of restricted benefit access points available to the client. The client may be restricted to accessing benefits at one or two locations, designated by the Department. The merchant or retailer would have to obtain telephone authorization of the transaction. Use of exception processing or key-entered transactions would not be allowed. This determination can only be imposed for a period not to exceed 24

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months and is designed to address situations of mismanagement, fraud, multiple replacement requests and intentional program violations.

6) Use of Specific Automated Teller Machine (ATM) Terminals - The Department may notify a client of restricted benefit access points available to the client. The client may be restricted to accessing benefits at one or two locations, designated by the Department. This determination can only be imposed for a period not to exceed 24 months and is designed to address situations of mismanagement, fraud, multiple replacement requests and intentional program violations.

7) Use of Protective, or Alternate, Payee - Repeated loss of the EBT card and PIN is a basis for a determination of client mismanagement and authorization of a Protective Payment Plan (PPP).

c) Other Remedies

The Department may use other remedies to reduce future claims and to address fraud, abuse, collusion or intentional program violations, as warranted by the individual case circumstances. Those remedies may include, but shall not be limited to:

1) disqualification;

2) penalties, fines and/or imprisonment consistent with federal and state law and regulations; and

3) referrals to federal law enforcement authorities, when appropriate.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Emergency Medical Services and Trauma Center Code

2) Code Citation: 77 Ill. Adm. Code 515

3)

Section Numbers:	Proposed Action:
515.100	New Section
515.125	New Section
515.150	New Section
515.160	New Section
515.170	New Section
515.210	New Section
515.220	New Section
515.230	New Section
515.300	New Section
515.310	New Section
515.320	New Section
515.330	New Section
515.340	New Section
515.350	New Section
515.360	New Section
515.370	New Section
515.380	New Section
515.390	New Section
515.400	New Section
515.410	New Section
515.420	New Section
515.430	New Section
515.440	New Section
515.500	New Section
515.510	New Section
515.520	New Section
515.530	New Section
515.540	New Section
515.550	New Section
515.560	New Section
515.570	New Section
515.580	New Section
515.590	New Section
515.600	New Section
515.610	New Section
515.700	New Section
515.710	New Section
515.720	New Section
515.730	New Section
515.740	New Section
515.750	New Section
515.800	New Section
515.810	New Section

515.320	New Section
515.330	New Section
515.300	New Section
515.310	New Section
515.320	New Section
515.330	New Section
515.335	New Section
515.340	New Section
515.345	New Section
515.350	New Section
515.355	New Section
515.360	New Section
515.365	New Section
515.370	New Section
515.375	New Section
515.380	New Section
515.385	New Section
515.390	New Section
515.395	New Section
515.1000	New Section
515.2000	New Section
515.2010	New Section
515.2020	New Section
515.2030	New Section
515.2040	New Section
515.2050	New Section
515.2060	New Section
515.2070	New Section
515.2080	New Section
515.2090	New Section
515.2100	New Section
515.3000	New Section
515.Appendix A	New Section
515.Appendix B	New Section
515.Appendix C	New Section
515.Appendix D	New Section
515.Appendix E	New Section
515.Appendix F	New Section

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50], as amended by Public Act 89-177, effective July 19, 1995

5) A Complete Description of the Subjects and Issues Involved: Public Act 89-177 (effective July 19, 1995) substantially amended the Emergency Medical Services (EMS) Systems Act. In response to these amendments to the authorizing statute, the Department is repealing its existing rules and adopting new rules implementing P.A. 89-177. Section 515.200, which establishes EMS regions, has already been adopted effective February 9,

1996.

Subpart A sets forth general requirements including definitions; incorporated and referenced materials; waiver provisions; procedures concerning violations, hearings and fines; and employer responsibility.

Requirements for EMS Regions are in Subpart B. [Section 515.200 is not included in this rulemaking, since it has already been adopted.] Subpart C establishes requirements for EMS Systems, including provisions for EMS System Program Plans; Approval and renewal of EMS Systems; data collection and submission; Do Not Resuscitate policies; and automated defibrillation.

Subpart D governs Emergency Medical Technicians, including training and testing, licensing and continuing education requirements; and renewals, reciprocity and inactive status.

Subpart E establishes rules for EMS Lead Instructors, Emergency Medical Dispatchers, First Responders, Pre-Hospital Registered Nurses, Emergency Communications Registered Nurses, and Trauma Nurse Specialists.

Vehicle Service Providers are regulated in Subpart F, and ambulance licensing requirements are listed. Specialized Emergency Medical Services Vehicle (SEMSV) Programs are regulated in Subpart G. These are vehicles or conveyances, other than those owned or operated by the federal government, primarily intended for use in transporting the sick or injured by means of air, water or ground transportation, and which are not ambulances.

Subpart H governs Trauma Centers, including designation criteria for Level I and Level II Trauma Centers; uniform reporting requirements; trauma patient evaluation and transfer; confidentiality and immunity; and pediatric care.

Subpart I governs administration of the EMS Assistance Fund, including application requirements, use of funds, and grantee responsibilities.

Appendices are in Subpart J.

The economic effect of this proposed rulemaking is unknown. Therefore, the Department requests any information that would assist in calculating this effect.

The Department anticipates adoption of this rulemaking approximately six to nine months after the publication of the notice in the *Illinois Register*.

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect? No

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7) Does this Rulemaking Contain an Automatic Repeal Date? No

8) Does this Rulemaking Contain Any Incorporations By Reference? Yes

9) Are there any other Proposed Amendments Pending on this Part? No

10) Statement of Statewide Policy Objectives: The rulemaking will affect municipalities and other units of local government that employ prehospital care providers.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking: Interested persons may present their comments concerning these rules by writing within 45 days after this issue of the *Illinois Register* to:

Ms. Gail M. DeVito
Division of Governmental Affairs
Illinois Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, IL 62761
(217) 782-6187

These rules may have an impact on small businesses. Any small business (as defined in the Illinois Administrative Procedure Act) commenting on these rules shall indicate their status as such, in writing, in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of Small Businesses, Small Municipalities and Not-for-Profit Corporations Affected: Hospitals, ambulance companies, volunteer rescue units.

B) Reporting, Bookkeeping or Other Procedures Required for Compliance: Quarterly reports, focused outcome analyses, ambulance run reports, personnel records as outlined in the rules.

C) Types of Professional Skills Necessary for Compliance: Skills required for licensure as prehospital care providers.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 515
EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE

SUBPART A: GENERAL

SUBPART B: EMS REGIONS

SUBPART C: EMS SYSTEMS

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

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SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

Section

SUBPART F: VEHICLE SERVICE PROVIDERS

Section

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section

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SUBPART H: TRAUMA CENTERS

Section

SUBPART I: EMS ASSISTANCE FUND

Section

SUBPART J: APPENDICES

Section

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50], as amended by Public Act 89-177, effective July 19, 1995.

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired, January 29, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; amended at 20 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

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Section 515.100 Definitions

For the purposes of this Part:

Act - the Emergency Medical Services (EMS) Systems Act (210 ILCS 50).

Advanced Life Support (ALS) Services - an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the Advanced Life Support national curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Aeromedical Crew Member or Watercraft Crew Member or Off-road SEMSV Crew Member - an individual, other than an EMS pilot, who has been approved by an SEMSV Medical Director for specific medical duties in a helicopter or fixed-wing aircraft, on a watercraft, or on an off-road SEMSV used in a Department-certified SEMSV Program.

Affiliate Trauma Hospital - a hospital which participates in an EMS system but is not a Level I or Level II Trauma Center.

Alternate EMS Medical Director or Alternate EMSMD - the physician who is designated by the Resource Hospital to direct the ALS/ILS/BLS operations in the absence of the EMS Medical Director.

Ambulance - any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated for the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such an individual. (Section 3.85 of the Act)

Ambulance Service Provider or Ambulance Provider - any individual, group of individuals, corporation, partnership, association, trust, joint venture, unit of local government or other public or private ownership entity that owns and operates a business or service using one or more ambulances or EMS vehicles for the transportation of emergency patients.

Associate Hospital - a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, fulfilling the

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same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs nor the responsibility for the overall operation of the EMS system program. The Associate Hospital must have a basic or comprehensive Emergency Department with 24-hour physician coverage. It must have a functioning Intensive Care Unit and/or a Cardiac Care Unit.

Associate Hospital EMS Coordinator - the EMT-P or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the ALS, ILS or BLS System, in accordance with the Department-approved EMS System Program Plan.

Associate Hospital EMS Medical Director - the physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the ALS, ILS, or BLS System, in accordance with the Department-approved EMS System Program Plan.

Basic Emergency Department - a classification of a hospital emergency department where at least one physician is available in the emergency department at all times; physician specialists are available in minutes; and ancillary services including laboratory, x-ray and pharmacy are staffed or are "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Code (77 Ill. Adm. Code 250).

Basic Life Support (BLS) Services - A basic level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in a Basic Life Support national curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Certified Registered Nurse Anesthetist or CRNA - a licensed registered professional nurse who has had additional education beyond the registered professional nurse requirements at a school program accredited by the National Council on Accreditation, and passed the certifying exam given by the National Council on Certification, and who by participating in 40 hours of continuing education every two years, has been recertified by the National Council on Recertification.

Channel, Half-Duplex - a radio channel that transmits and receives signals, but in only one direction at a time.

Comprehensive Emergency Department - a classification of a hospital

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emergency department where at least one licensed physician is available in the emergency department at all times; physician specialists shall be available in minutes; and ancillary services including laboratory and x-ray are staffed at all times; and pharmacy is staffed or "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Code (77 Ill. Adm. Code 250).

Department - the Illinois Department of Public Health. (Section 3.5 of the Act)

Director - the Director of the Illinois Department of Public Health or his/her designee. Section 3.5 of the Act)

Dysrhythmia - a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and conduction.

Effective Radiated Power (ERP) - the power gain of a transmitting antenna multiplied by the net power accepted by the antenna from the connected transmitter.

Electrocardiogram (EKG) - a single lead graphic recording of the electrical activity of the heart by a series of deflections that represent certain components of the cardiac cycle.

Emergency - a medical condition of recent onset and severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Section 3.5 of the Act)

Emergency Communications Registered Nurse or ECRN - a registered professional nurse, licensed under the Illinois Nursing Act of 1987 who has successfully completed supplemental education in accordance with this Part, and who is approved by an EMS Medical Director to monitor telecommunications from and give voice orders to EMS System personnel, under the authority of the EMS Medical Director and in accordance with System protocols. (Section 3.80 of the Act) These individuals were formerly called MICNS.

Emergency Medical Dispatcher - a person who has successfully completed a dispatching course meeting or exceeding the national curriculum of the United States Department of Transportation in accordance with this Part, who accepts calls from the public for emergency medical services and dispatches designated emergency medical services personnel and vehicles. (Section 3.70 of the Act)

Emergency Medical Services (EMS) System or System - an organization of hospitals, vehicle service providers and personnel approved by the

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Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS and/or ALS level pursuant to a System program plan submitted to and approved by the Department and pursuant to the EMS Region Plan adopted for the EMS Region in which the System is located. (Section 3.20 of the Act)

Emergency Medical Services System Survey - a questionnaire that provides data to the Department for the purpose of compiling annual reports.

Emergency Medical Technician-Basic or EMT-B - a person who has successfully completed a course of instruction in basic life support as prescribed by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part *and practices within an EMS System.* (Section 3.50 of the Act)

Emergency Medical Technician-Coal Miner - for purposes of the Coal Mine Medical Emergencies Act, an EMT-B, EMT-I or EMT-P who has received training emphasizing extrication from a coal mine.

Emergency Medical Technician-Intermediate or EMT-I - a person who has successfully completed a course of instruction in intermediate life support as prescribed by the Act and this Part *and practices within an Intermediate or Advanced Life Support EMS System.* (Section 3.50 of the Act)

Emergency Medical Technician-Paramedic or EMT-P - a person who has successfully completed a course of instruction in advanced life support care as prescribed by the Department, is licensed by the Department in accordance with standards prescribed by the Act and this Part *and practices within an Advanced Life Support EMS System.* (Section 3.50 of the Act)

EMS Administrative Director - the administrator, appointed by the Resource Hospital with the approval of the EMS Medical Director, responsible for the administration of the EMS System.

EMS Medical Director or EMSMD - The physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

EMS Lead Instructor - a person who has successfully completed a course of education as prescribed by the Department in this Part, and who is currently approved by the Department to coordinate or teach education, training and continuing education courses, in accordance with this Part. (Section 3.65 of the Act)

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EMS Regional Plan - a plan established by the EMS Medical Director's Committee in accordance with Section 3.30 of the Act.

EMS System Coordinator - the designated individual responsible to the EMS Medical Director and EMS Administrative Director for coordination of the educational and functional aspects of the System program.

EMS System Program Plan - the document prepared by the Resource Hospital and approved by the Department that describes the EMS System program and directs the program's operation.

First Responder - a person who has successfully completed a course of instruction in emergency first response as prescribed by the Department, who provides first response services prior to the arrival of an ambulance or specialized emergency medical service vehicle, in accordance with the level of care established in the emergency first response course. (Section 3.60 of the Act)

First Response Services - a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and controlling of bleeding, as outlined in the First Responder curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.60 of the Act)

Fixed-wing aircraft - an engine-driven aircraft that is heavier than air, and is supported in-flight by the dynamic reaction of the air against its wings.

Full-Time - on duty a minimum of 36 hours, four days a week.

Health Care Facility - a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed. It does not include "pre-hospital emergency care settings" which utilize EMTs to render pre-hospital emergency care prior to the arrival of a transport vehicle, as defined in the Act and this Part. (Section 3.5 of the Act)

Helicopter or Rotorcraft - an aircraft that is capable of vertical take offs and landings, including maintaining a hover.

Hospital - *has the meaning ascribed* to that term in Section 3 of the *Hospital Licensing* Act [210 ILCS 85]. (Section 3.5 of the Act)

Instrument Flight Rules or IFR - the operation of an aircraft in weather minimums below the minimums for flight under visual flight rules (VFR). (See General Operating and Flight Rules, 14 CFR 91.115 through 91.129.)

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Instrument Meteorological Conditions (IMC) - meteorological conditions expressed in terms of visibility, distance from clouds and ceiling, which require Instrument Flight Rules.

Intermediate Life Support (ILS) Services - an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures as outlined in the Intermediate Life Support national curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Level I Trauma Center - a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2030 of this Part to provide optimal care to trauma patients and to provide all essential services in-house, 24 hours per day.

Level II Trauma Center - a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2040 of this Part to provide optimal care to trauma patients, to provide some essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day.

Limited Operation Vehicle - A vehicle which is licensed by the Department to provide basic, intermediate or advanced life support emergency or non-emergency medical services that are exclusively limited to specific events or locales. (Section 3.85 of the Act)

Local System Review Board - a group established by the Resource Hospital to hear appeals from EMTs or other providers who have been suspended or have received notification of suspension from the EMS Medical Director.

Mobile Radio - a two-way radio installed in an EMS vehicle which may not be readily removed.

Morbidity - a negative outcome that is the result of the original trauma and/or treatment rendered or omitted.

911 - an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services including police, fire, medical ambulance and rescue.

Non-emergency Medical Care - medical services rendered to patients whose condition does not meet the Act's definition of emergency, during transportation of such patients to health care facilities for the purpose of obtaining medical or health care services which are not

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emergency in nature, using a vehicle regulated by the Act and this Part. (Section 3.10 of the Act)

Off-Road Specialized Emergency Medical Services Vehicle or Off-Road SEMSV or Off-Road SEMS Vehicle - a motorized cart, golf cart, all-terrain-vehicle (ATV), or amphibious vehicle that is not intended for use on public roads.

Participating Hospital - a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital.

Physician - any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 (225 ILCS 90).

Pilot or EMS Pilot - a pilot certified by the Federal Aviation Administration who has been approved by an SEMSV Medical Director to fly a helicopter or fixed-wing aircraft used in a Department-certified SEMSV Program.

Portable Radio - a hand-held radio that accompanies the user during the conduct of emergency medical services.

Pre-Hospital Care - those emergency medical services rendered to emergency patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to hospitals. (Section 3.10 of the Act)

Pre-Hospital Care Provider - a System Participant or any EMT-B, I, P, Ambulance, Ambulance Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN or Physician serving on an amoulance or giving voice orders over an EMS System and subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

Pre-Hospital Registered Nurse or Pre-Hospital RN - A registered professional nurse, licensed under the Illinois Nursing Act of 1987 who has successfully completed supplemental education in accordance with this Part and who is approved by an EMS Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports. Section 3.80 of the Act) This individual was formerly called a Field RN.

Regional EMS Advisory Committee - a committee formed within an Emergency Medical Services (EMS) Region to advise the Region's EMS

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Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each resource hospital within the Region, one administrative representative from an associate hospital within the Region, one administrative representative from a participating hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a vehicle service provider from each System within the Region, one Emergency Medical Technician (EMT) Pre-Hospital RN from each level of EMT/Pre-Hospital RN practicing within the Region, and one registered professional nurse currently practicing in an emergency department within the Region. Of the two administrative representatives of vehicle service providers, at least one shall be an administrative representative of a private vehicle service provider. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee. (Section 3.25 of the Act)

Regional EMS Coordinator - the designee of the Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health.

Regional EMS Medical Directors Committee - a group *comprised of the Region's EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For regions which include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other regions, the fire department vehicle service providers shall select which medical advisor to serve on the Committee on an annual basis.* (Section 3.25 of the Act)

Regional Trauma Advisory Committee - a committee formed within an Emergency Medical Services (EMS) Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each trauma center with the Region, one EMS Medical Director from a resource hospital within the Region, one EMS System Coordinator from another resource hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each trauma center within the Region, one EMT representing the highest level of EMT practicing within the Region, one emergency physician and one Trauma Nurse Specialist (TNS) currently practicing in a trauma center. The Department's Regional EMS Coordinator for each region shall serve as a non-voting member of that Region's Trauma Advisory

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Committee. (Section 3.25 of the Act)

Registered Nurse or Registered Professional Nurse or RN - a person who is licensed as a professional nurse under the Illinois Nursing Act of 1987 (225 ILCS 65).

Resource Hospital - the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire program, including the clinical aspects, operations and educational programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

SEMSV Medical Control Point or Medical Control Point - the communication center from which the SEMSV Medical Director or his or her designee issues medical instructions or advice to the aeromedical, watercraft, or off-road SEMSV crew members.

SEMSV Medical Director or Medical Director - the physician appointed by the SEMSV Program who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part.

SEMSV Program or Specialized Emergency Medical Services Vehicle Program - a program operating within an EMS System, pursuant to a program plan submitted to and certified by the Department, utilizing specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

Specialized Emergency Medical Services Vehicles or SEMSV - a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads. (Section 3.35 of the Act) "Primarily intended", for the purposes of this definition, means one or more of the following:

Over 50 percent of the vehicle's operational (e.g., in-flight) hours are devoted to the emergency transportation of the sick or injured;

The vehicle is owned or leased by a hospital or ambulance provider and is used for the emergency transportation of the sick or injured;

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The vehicle is advertised as a vehicle for the emergency transportation of the sick or injured;

The vehicle is owned, registered or licensed in another state and is used on a regular basis to pick up and transport the sick or injured within or from within this State; or

The vehicle's structure or permanent fixtures have been specifically designed to accommodate the emergency transportation of the sick or injured.

Standby Emergency Department - a classification of a hospital emergency department where at least one of the registered nurses on duty in the hospital is available for emergency services at all times and a licensed physician is "on-call" to the emergency department at all times in accordance with Section 250.710 of the Hospital Licensing Code (77 Ill. Adm. Code 250).

Special-Use Vehicle - any public or privately owned vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated solely for the emergency or non-emergency transportation of a specific medical class or category of persons who are sick, injured, wounded or otherwise incapacitated or helpless (e.g., high-risk obstetrical patients, neonatal patients). (Section 3.85 of the Act)

State EMS Advisory Council - a group that advises the Department on the administration of the Act and this Part whose members are appointed in accordance with Section 3.200 of the Act.

System Participation Suspension - the suspension from participation within an EMS System of an individual or individual provider, as specifically ordered by that System's EMS Medical Director.

Substantial Compliance - meeting requirements except for variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Substantial Failure - the failure to meet requirements other than a variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Sustained Hypotension - two systolic blood pressures of 90 mm.Hg five minutes apart or, in the case of a pediatric patient, two systolic blood pressures of 80 mm.Hg five minutes apart.

Telecommunications Equipment - a radio capable of transmitting and/or

receiving voice and electrocardiogram (EKG) signals.

Telemetry - the transmission of data by wire, radio, or other means from remote sources to a receiving station for recording and analysis.

Trauma - any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)

Trauma Category I - a classification of trauma patients in accordance with Section 515.Appendix C and 515.Appendix F of this Part.

Trauma Category II - a classification of trauma patients in accordance with Section 515.Appendix C and 515.Appendix F of this Part.

Trauma Center - A hospital which: within designated capabilities provides care to trauma patients; participates in an approved EMS System; and is duly designated pursuant to the provisions of the Act. (Section 3.90 of the Act)

Trauma Center Medical Director - the trauma surgeon appointed by a Department-designated Trauma Center who has the responsibility and authority for the coordination and management of patient care and trauma services at the Trauma Center. He or she must have 24-hour independent operating privileges and shall be board certified in surgery with at least one year of experience in trauma care.

Trauma Center Medical Directors Committee - a group composed of *the Region's Trauma Center Medical Directors.* (Section 3.25 of the Act)

Trauma Coordinator - a registered nurse working in conjunction with the trauma medical director. The Trauma Coordinator is responsible for the organization of service and systems necessary for a multidisciplinary approach throughout the continuum of trauma care.

Trauma Nurse Specialist or TNS - a registered professional nurse who has successfully completed education and testing requirements as prescribed by the Department, and is certified in accordance with this Part. (Section 3.75 of the Act)

Trauma Nurse Specialist Course Coordinator (TNSCC) - a registered nurse appointed by the Chief Executive Officer of a hospital designated as a TNS Training Site, who meets the requirements of Section 515.570 of this Part.

Trauma Service - an identified hospital surgical service in a Level I or Level II Trauma Center functioning under a designated trauma director in accordance with Sections 515.2030(c) and 515.2040(c) of this Part.

Unit Identifier - a number assigned by the Department for each EMS vehicle in the State to be used in radio communications.

Vehicle Service Provider - an entity licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act and this Part *and an operational plan approved by its EMS System(s), utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV).* (Section 3.85 of the Act)

Watercraft - a nautical vessel, boat, airboat, hovercraft or other vehicle that operates in, on or across water.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.125 Incorporated and Referenced Materials

a) The following regulations and standards are incorporated in this Part:
   1) Private and professional association standards:
      A) Glasgow Coma Scale
         Champion HR, Sacco WJ, Carnazzo AJ et al.:
         CritCare Med 9(9): 672-676 (1981)
      B) Revised Trauma Score, 1993 from Resources for the Optimal Care of the Injured Patient
         American College of Surgeons
         55 East Erie St.
         Chicago, Illinois 60611-2797
      C) Abbreviated Injury Score, 1990
         American Association for the Advancement of Automotive Medicine
         Des Plaines, Illinois 60008
      D) Injury Severity Score
         Baker SP, O'Neil B, Haddon W et al.:
         Journal of Trauma 14: 187-196 (1974)
      E) International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
         Alphapetic Index to External Causes of Injury (E-Codes), Second Printing (1980)
         World Health Organization, Geneva, Switzerland and
         National Center for Health Statistics
         Published by Edwards Brothers, Inc. Ann Arbor, Michigan
      F) Resources for Optimal Care of the Injured Patient (1993)
         American College of Surgeons
         55 East Erie St.
         Chicago, Illinois 60611-2797
      G) Pediatric Advanced Life Support (1995
         American Heart Association National Center
         7272 Greenville Center

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2) Federal government publications:

A) Federal Specifications for Ambulance, KKK-A-1822D (November, 1984), United States General Services Administration, Specifications Section
Room 6654, 7th and D Streets, S.W., Washington, D.C. 20407

B) United States Department of Transportation, Emergency Medical Technician - Basic: National Standard Curriculum (1994), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

C) United States Department of Transportation, Emergency Medical Technician - Intermediate: National Standard Curriculum (1985), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

D) United States Department of Transportation, Emergency Medical Technician - Paramedic: National Standard Curriculum (1985), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. See Sections 515.215(a); 515.320(c) and (e); 515.510(a) and (d); 515.530(c); 515.532(b); 515.810(b) and (c); and 515.850(a) and (b).)

E) United States Department of Transportation, First Responder: National Standard Curriculum (1995), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

F) United States Department of Transportation, EMS Instructor Training Program: National Standard Curriculum (1995), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

G) United States Department of Transportation, Emergency Medical Dispatcher: National Standard Curriculum (1995), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

3) Federal regulations:

A) 47 CFR 90 (October 1, 1994) - Private Land Mobile Radio Services

B) Air Taxi Operations and Commercial Operators (14 CFR 135, (1990), Subparts A, Sections 135.1 through 135.43; B, Sections 135.61 through 135.125; C, Sections 135.141 through 135.185; D, Sections 135.201 through 135.229; E, Sections 135.241 through 135.247; F, Section 135.261; J, Sections 135.411 through 135.443)

C) 42 CFR 2A (October 1, 1995) - Confidentiality of Alcohol and Drug Abuse Patient Records

b) All incorporations by reference of federal regulations and the standards of nationally recognized organizations refer to the

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regulations and standards on the date specified and do not include any additions or deletions subsequent to the date specified.

c) The following statutes and State regulations are referenced in this Part:

1) Federal statutes:

A) U.S. Code 42, the Public Health and Welfare, 42 U.S.C. 300 g-1(a) (1991)

B) Federal Aviation Act of 1958, Sections 307 and 308 (P.L. 85-726, 72 U.S.C. 731)

2) State of Illinois statutes:

A) Hospital Emergency Services Act (210 ILCS 80)

B) Hospital Licensing Act (210 ILCS 85)

C) Medical Practice Act of 1987 (225 ILCS 60)

D) The Illinois Nursing Act of 1987 (225 ILCS 65)

E) Code of Civil Procedure (735 ILCS 5)

F) Emergency Telephone System Act (50 ILCS 750)

G) Boat Registration and Safety Act (625 ILCS 45)

H) Open Meetings Act (5 ILCS 120)

I) Illinois Administrative Procedure Act (5 ILCS 100)

J) Head and Spinal Cord Injury Act (410 ILCS 515)

K) Freedom of Information Act (5 ILCS 140)

L) State Records Act (5 ILCS 160)

M) Coal Mine Medical Emergencies Act (410 ILCS 15)

3) State of Illinois regulations:

A) Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

B) Hospital Licensing Requirements (77 Ill. Adm. Code 250)

C) Aviation Safety (92 Ill. Adm. Code 14.790, 14.792, 14.795)

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.150 Waiver Provisions

a) *The Department may grant a waiver to any provision of the Act or this Part for a specified period of time determined appropriate by the Department. The Department may grant a waiver when it can be demonstrated that there will be no reduction in standards of medical care as determined by the EMS Medical Director or the Department.* (Section 3.185 of the Act)

b) *Any entity may apply in writing to the Department for a waiver to specific requirements or standards for which it considers compliance to be a hardship.* Section 3.185 of the Act) The application shall contain the following information:

1) The applicant's name, address, and license number (if applicable);

2) The Section of the Act or this Part for which the waiver is being sought;

3) An explanation of why the applicant considers compliance with the Section to be a hardship, including a description of how the applicant has attempted to comply with the Section;

4) The period of time for which the waiver is being sought;

5) An explanation of how the waiver will not reduce the quality of medical care established by the Act and this Part; and

6) If the applicant is a System Participant, the applicant's EMS Medical Director shall state in writing whether he/she recommends or opposes the application for waiver, the reason for such recommendation or opposition, and statement of how the waiver will or will not reduce the quality of medical care established by the Act and this Part. The applicant shall submit the EMSMD's statements along with the application for waiver. If the EMSMD does not provide written statements within 30 days of the applicant's request, the application may be submitted to the Department and the EMSMD will be determined to be in support of the waiver.

c) An EMS Medical Director may apply to the Department for a waiver on behalf of a System Participant by submitting an application that contains all of the information required by subsection (b) of this Section, along with a statement signed by the System Participant requesting or authorizing the EMSMD to make such application.

d) The Department shall grant the requested waiver if it finds the following:

1) The waiver will not reduce the quality of medical care established by the Act and this Part; and

2) Full compliance with the regulation at issue is or would be a hardship on the applicant;

3) For an EMT seeking a waiver to extend a relicensure date in order to complete relicensure requirements,

A) The EMT has previously received no more than one extension since his or her last relicensure; and

B) The EMT has not established a pattern of seeking extensions (e.g., waivers sought based on the same type of hardship in two or more previous license periods);

4) For an applicant other than an EMT,

A) The applicant has previously received no more than one waiver of the same regulation during the current license or designation year;

B) The applicant has not established a pattern of seeking waivers of the same regulation during previous license or designation years; and

C) The Department finds that the hardship preventing compliance with the particular regulation is not of an ongoing nature;

5) For a hospital requesting a waiver to participate in a System other than that in which the hospital is geographically located,

A) Documentation that transfer patterns support the request; and

B) Historic patterns of patient referrals.

f) When granting a waiver, the Department shall specify the regulation or portion thereof that is being waived, any alternate requirement that the waiver applicant shall meet, and any procedures or timetable that the waiver applicant shall follow to achieve compliance with the waived regulation.

g) The Department shall determine the length of any waiver that it grants, based on the nature and extent of the hardship and the medical needs of the community or areas in which the waiver applicant functions.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.160 Violations, Hearings and Fines

a) *Except for emergency suspension orders, or actions initiated pursuant to Section 3.90(b)(10) of the Act, prior to initiating an action for suspension, revocation, denial, nonrenewal, or imposition of a fine, the Department shall:*

1) *Issue a Notice of Violation which specifies the Department's allegations of noncompliance and requests a plan of correction to be submitted within 10 days after receipt of the Notice of Violation;*

2) *Review and approve or reject the plan of correction. If the Department rejects the plan of correction, it shall send notice of the rejection and the reason for the rejection. The party shall have 10 days after receipt of the notice of rejection in which to submit a modified plan;*

3) *Impose a plan of correction if a modified plan is not submitted in a timely manner or if the modified plan is rejected by the Department;*

4) *Issue a Notice of Intent to fine, suspend, revoke, nonrenew or deny if the party has failed to comply with the imposed plan of correction, and provide the party with an opportunity to request an administrative hearing. The Notice of Intent shall be effected by certified mail or by personal service, shall set forth the particular reasons for the proposed action, and shall provide the party with 15 days in which to request a hearing. (Section 3.130 of the Act)*

b) *Administrative hearings shall be conducted by the Director or his/her designee. On the basis of any such hearing, or upon default of the Respondent, the Director shall issue a Final Order specifying his findings, conclusions and decision. A copy of the Final Order shall be sent to the Respondent by certified mail or served personally upon the Respondent. (Section 3.135 of the Act)*

c) *The procedure governing hearings authorized by the Act shall be in accordance with the Department's rules governing administrative*

hearings (77 Ill. Adm. Code 100). (Section 3.135 of the Act)

d) The Department shall have the authority to impose fines on any licensed vehicle service provider, designated trauma center, resource hospital, associate hospital or participating hospital. (Section 3.140(a) of the Act)

e) In determining the amount of a fine, the Director shall consider the following factors:

1) The severity of the actual or potential harm to an individual.

2) The numbers and types of protocols, standards, rules or Sections of the Act that were violated in the course of creating the condition or occurrence at issue.

3) The reasonable diligence exercised by the facility, pre-hospital care provider or System participant to avoid the violation(s) or to reduce the potential harm to individuals.

4) Efforts by the facility, pre-hospital care provider or System participant to correct the violation(s).

5) Any previous violation(s) of a like or similar nature by the facility, pre-hospital care provider or System participant.

6) Any financial benefit to the facility, pre-hospital care provider or System participant of continuing the violation(s).

f) A fine not exceeding $10,000 shall be issued for a violation which created a condition or occurrence presenting a substantial probability that death or serious harm to an individual will or did result therefrom. (Section 3.140(b)(1) of the Act)

g) A fine not exceeding $5,000 shall be issued for a violation which creates or created a condition or occurrence which threatens the health, safety or welfare of an individual. (Section 3.140(b)(2) of the Act)

h) A Notice of Intent to Impose Fine may be issued in conjunction with or in lieu of a Notice of Intent to Suspend, Revoke, Nonrenew or Deny, and shall (Section 3.140(c) of the Act) include:

1) A description of the violation(s) for which the fine is being imposed.

2) A citation to the Sections of the Act, rules, protocols or standards alleged to have been violated.

3) The amount of the fine.

4) The opportunity to request an administrative hearing prior to imposition of the fine, provided such request for a hearing is made within 15 days after receipt of the notice.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.170 Employer Responsibility

a) No employer shall employ or permit any employee to perform any services for which a license, certificate or other authorization is required by the Act or this Part unless and until the person so employed possesses all licenses, certificates or authorizations that are so required. (Section 3.160(a) of the Act)

b) Any person or entity that employs or supervises a person's activities as a First Responder or Emergency Medical Dispatcher shall cooperate with the Department's efforts to monitor and enforce compliance by those individuals with the requirements of the Act or this Part. (Section 3.160(b) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART B: EMS REGIONS

Section 515.210 EMS Regional Plan Development

a) Within six months after designation of an EMS region, an EMS region plan addressing at least the information prescribed in Section 515.220 of this Part shall be submitted to the Department for approval. The plan shall be developed by the Region's EMS Medical Directors Committee with advice from the Regional EMS Advisory Committee; portions of the plan concerning trauma shall be developed jointly with the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, with advice from the Regional Trauma Advisory Committee, if such Advisory Committee has been established in the Region. (Section 3.25(a) of the Act)

b) A Region's Trauma Center Medical Directors may choose to participate in the development of the EMS Region Plan through membership on the Regional EMS Advisory Committee, rather than through a separate Trauma Center Medical Directors Committee. If that option is selected, the Region's Trauma Center Medical Director shall also determine whether a separate Regional Trauma Advisory Committee is necessary for the Region. (Section 3.25(b) of the Act)

c) In the event of disputes over content of the Plan between the Region's EMS Medical Directors Committee and the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, the Director of the Illinois Department of Public Health shall intervene through a review in accordance with Section 515.230 of this Part. Section 3.25(c) of the Act)

d) Every 2 years, the members of the Region's EMS Medical Directors Committee shall rotate serving as Committee Chair, and select the Associate Hospital, Participating Hospital and Vehicle service providers which shall send representatives to the Advisory Committee, and the EMTs,Pre-Hospital RN and nurse who shall serve on the Advisory Committee. (Section 3.25(d) of the Act) Each System in the Region must have at least one representative on the Committee.

e) Every 2 years, the members of the Trauma Center Medical Directors Committee shall rotate serving as Committee Chair, and select the vehicle service providers, EMT, emergency physician, EMS System

Coordinator and TNS who shall serve on the Advisory Committee. (Section 3.25(e) of the Act) It is recommended that the committee chair be held by Trauma Center Medical Directors of the Level I Trauma Centers in the Region.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.220 EMS Regional Plan Content

a) *The EMS Medical Directors Committee* portion of the Regional Plan *shall address at least the following:*
   1) *Protocols for inter-System/inter-Region patient transports, including* protocols for pediatric patients and pediatric patients with special health care needs, *identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their Department classifications and relevant Regional considerations (e.g., transport times and distances);*
   2) *Regional standing medical orders;*
   3) *Patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal;*
   4) *Protocols for resolving Regional or Inter-System conflict;*
   5) *An EMS disaster preparedness plan which includes the actions and responsibilities of all EMS participants with the Region* for care and transport of both the adult and pediatric population;
   6) *Regional standardization of continuing education requirements;*
   7) *Regional standardization of Do Not Resuscitate (DNR) policies, and protocols for power of attorney for health care;*
   8) *Protocols for disbursement of Department grants* (Section 3.20(a)(1-8) of the Act); and
   9) Development of protocols to improve and integrate EMS for children (or EMSC) into the current delivery of emergency services within the Region.

b) *The Trauma Center Medical Directors or Trauma Center Medical Directors Committee* portion of the Regional Plan *shall address at least the following:*
   1) *The identification of Regional Trauma Centers* and identification of trauma centers that specialize in pediatrics;
   2) *Protocols for inter-System and inter-Region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their Department classifications and relevant Regional considerations (e.g., transport times and*

distances);
   3) *Regional trauma standing medical orders;*
   4) *Trauma patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal* (These policies must include the criteria of Section 515.Appendix C.);
   5) *The identification of which types of patients can be cared for by Level I and Level II Trauma Centers;*
   6) *Criteria for inter-hospital transfer of trauma patients* including the transfer of pediatric patients;
   7) *The treatment of trauma patients in each trauma center within the Region;*
   8) *The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to the Department; and*
   9) *A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients* (Section 3.30(b)(1-3) of the Act).
      A) This shall include but not be limited to all cases that have been deemed potentially preventable or preventable in the trauma center review using the American College of Surgeons "Guidelines for Judgement Regarding Mortality and Contributing Factors and Guidelines Related to Morbidity and Mortality" (from "Resources for Optimal Care of the Injured Patient"). This review should exclude trauma patients who were dead on arrival;
      B) In addition, the review must include all patients who were transferred more than two hours from time of arrival at the initial institution and who meet one or more of the following criteria at the receiving trauma center:
         i) Admitted to an intensive care unit;
         ii) Admitted to a bed with telemetry monitoring;
         iii) Went directly to the operating room;
         iv) Went to the operating room from the Emergency Department;
         v) Discharged to a rehabilitation or skilled care facility;
         vi) Died following arrival.
      C) The region must include a review of morbidity/audit filters that have been determined by the region.
      D) Cumulative regional reports will be made available upon

request from the Department.

c) *The Region's EMS Medical Directors and Trauma Center Medical Directors Committees shall appoint any subcommittees which they deem necessary to address specific issues concerning Region activities.* (Section 3.30(c) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.230 Resolution of Disputes Concerning the EMS Regional Plan

a) If the EMS Medical Director's Committee and the Region's Trauma Center Medical Directors or Trauma Center Medical Director's Committee, whichever is applicable, have an unresolved dispute over the content of the Regional Plan, the following shall be sent to the Director:
   1) All relevant information surrounding the issue being disputed.
   2) A statement from the EMS Medical Director's Committee supporting their position; and the name, phone number and address of one person who should be contacted if further information is needed.
   3) A statement from the Region's Trauma Center Medical Director or Trauma Center Medical Director's Committee, whichever is applicable, supporting their position; and the name, phone number and address of one person who would be contacted if further information is needed.

b) The Director will make a determination within 10 working days after receipt of the above information. The determination may be one of the other position or may be another option developed by the Director.

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART C: EMS SYSTEMS

Section 515.300 Approval of New EMS Systems

Beginning September 1, 1997, the Department shall approve the development of a new EMS System only when a local or regional need for establishing such System has been identified Section 3.20(c)(1) of the Act). The applicant shall submit documentation addressing the following:

a) A clear description of its current role and status within the existing System;

b) Its rationale for separating from the existing System and developing its own program;

c) A description of the methods to be used for ensuring the coordination of emergency services with adjacent Systems, including the System that it proposes to leave;

d) A statement detailing the effect that the proposed change will have on the area's pre-hospital services and patient referral patterns;

e) A statement summarizing the steps to be taken to ensure that the necessary quality and level of care will be maintained during the implementation phase of the proposed System; and

f) A letter of support or denial from the Regional Advisory Committee.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.310 Approval and Renewal of EMS Systems

a) All applicants for EMS System approval shall submit to the Department three copies of a written EMS System Program Plan that complies with Section 515.330 of this Part and is signed by the EMS Medical Director.
   1) The Plan shall clearly identify any portion or item that is not expected to be fully operational by the date of Department approval, and shall specify the expected date for full operation of such portion or item, which shall not exceed one year after Department approval has been issued.
   2) The Department shall expect all portions of the proposed Plan to be fully operational upon Department approval unless otherwise identified pursuant to this Section.

b) The Department shall review a submitted Program Plan and notify the applicant of any corrections that must be submitted in order to complete the Plan. The Department shall also require the applicant to submit a formal waiver request for any item or portion identified as having a delayed operational date, if the Department finds that:
   1) The item or length of operational delay has not previously been authorized by the Department for other EMS Systems, or
   2) The delay would appear to prevent the System from operating in substantial compliance with the Act or this Part upon approval, or
   3) The delay would appear potentially to reduce the quality of medical EMS care established by the Act and this Part.

c) The Department shall conduct an on-site inspection of the applicant Resource Hospital within ninety days after a Program Plan has been accepted as complete.

d) The Department shall issue a letter of approval to the applicant EMS System if the inspection indicates compliance with the approved Program Plan, the Act and this Part. The letter shall indicate the level(s) of service that the System is authorized to provide (ALS, ILS, BLS).

e) A System approval shall be valid for a period of four years except as allowed in subsection (b) of this Section.

f) A System seeking renewal of approval shall submit a written request to the Department at least ninety days prior to its renewal date. The request shall include any proposed revisions to the Program Plan and updates of all letters of commitment required by Section 515.330.

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g) The Department shall review the request for renewal and notify the System of any corrections that must be submitted to complete the update of the Program Plan.

h) The Department shall conduct an on-site renewal inspection of the Resource Hospital during each four-year approval period, and shall conduct additional inspections of any System hospital or vehicle provider as necessary to ensure compliance with the Program Plan, the Act and this Part.

i) The Department shall issue a letter of renewal approval to the EMS System if the Program Plan is complete, the inspection indicated substantial compliance with the approved Program Plan, the Act and this Part, and there is no Department legal action pending against the System. The letter shall indicate the level(s) of service that the System is authorized to provide (ALS, ILS, BLS).

j) An approved EMS System shall amend its Program Plan by submitting to the Department three copies of the entire portion or Section in which the change is proposed, along with a letter signed by the EMS Medical Director that describes the reason(s) for the change. The amendment shall not be implemented until approval has been granted by the Department.

k) Changes in any of the following shall be considered modifications of a System Program Plan requiring submission of a proposed amendment:

1) EMS Medical Director;
2) Resource, Associate or Participating Hospital, or their specific roles;
3) System service area;
4) Written standing orders and policies;
5) Method(s) of providing EMS services;
6) Additional vehicle service providers, or changes in their levels of service, specific roles or response areas;
7) Access and dispatch procedures and mechanisms;
8) Communications plan;
9) Equipment and drug requirements;
10) Training, continuing education and/or examination requirements;
11) Quality assurance policies;
12) Data collection and evaluation policies;
13) Override or bypass/diversion policies;
14) Disciplinary or suspension policies or procedures.

l) All EMS Systems in existence upon the adoption of this Section shall submit to the Department a revised Program Plan that conforms to the requirements of this Part. The Department will approve Program Plans that meet the requirements of this Part and will establish renewal dates for EMS System approval.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.320 Scope of EMS Service

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a) All Basic Life Support (BLS), Intermediate Life Support (ILS), and Advanced Life Support (ALS) services, as defined in the Act, shall be provided through EMS Systems. An individual System shall operate at one or more of those levels of service, as specified in its Program Plan and the Department's letter of approval, using vehicles licensed by the Department pursuant to the Act and this Part.

b) All pre-hospital, inter-hospital and non-emergency medical care, as defined in the Act, shall be provided through EMS Systems, using the levels of Department licensed or approved personnel required by the Act and this Part.

c) An EMS System shall designate a Resource Hospital, which shall have the authority and responsibility for the System, through the EMS Medical Director, as described in the Act, this Part and the System Program Plan.

d) *All other hospitals which are located within the geographic boundaries of a System and which have standby, basic or comprehensive level emergency departments must function in that System as either an Associate Hospital or Participating Hospital and follow all System policies specified in the System Program Plan* (Section 3.20(b) of the Act).

1) All hospitals that are not already formally affiliated with a System shall do so within sixty days after the effective date of this Section. A hospital may have a secondary affiliation with another system or may request a waiver to participate in a system other than that in which the hospital is geographically located. (See Section 515.150(d)(5).)

2) Every System hospital shall identify the level of its emergency department services in its letter of commitment, which is part of the EMS System Program Plan to be submitted to the Department.

3) An "Associate Hospital" shall provide the same clinical and communications services as the Resource Hospital, but shall not have the primary responsibility for personnel training and System operations. It shall have a basic or comprehensive emergency department with 24-hour physician coverage and a functioning intensive care and/or cardiac care unit.

4) A "Participating Hospital" may or may not have communications/monitoring capabilities.

5) All System hospitals shall agree to replace medical supplies and provide for equipment exchange for System vehicles.

6) All System hospitals monitoring telecommunications from EMS field personnel shall provide voice orders either by the EMS Medical Director, a physician appointed by the EMS Medical Director, or an Emergency Communications Registered Nurse (ECRN).

7) All System hospitals shall allow the Department, the EMS Medical Director and EMS System Coordinator access to all records, equipment, vehicles and personnel during their activities evaluating the Act and this Part.

e) The Resource Hospital shall appoint an EMS Medical Director (EMSMD).

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For an *ILS or ALS level EMS system* the EMSMD shall be a *physician licensed to practice medicine in all of its branches in Illinois, and certified by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine, and* for a *BLS level EMS System* the EMSMD shall *be a physician licensed to practice medicine in all of its branches in Illinois, with regular and frequent involvement in pre-hospital emergency medical services. In addition, all EMSMDS shall:*

1) *Have experience on an EMS vehicle at the highest level available within the System, or make provision to gain such experience within 12 months prior to the date responsibility for the system is assumed or within 90 days after assuming the position; and*
2) *Be thoroughly knowledgeable of all skills included in the scope of practices of all levels of EMS personnel within the system; and*
3) *Have or make provision to gain experience instructing students at level similar to that of the levels of EMS personnel within the System; and*
4) *For ILS and ALS EMS Medical Directors, successfully complete a Department-approved EMS Medical Director's Course.* (Section 3.20(c)(6) of the Act)

f) The *EMS Medical Director* shall *appoint an alternate EMS Medical Director and establish a written protocol addressing the functions to be carried out in his or her absence* (Section 3.35(b) of the Act).

g) An EMS System utilizing Specialized Emergency Medical Service Vehicles (SEMSVs) shall appoint and/or approve the SEMSV Medical Director(s) to manage and direct the use of SEMSVs and their personnel within the System. He or she shall be a physician who has met at least the following qualifications:

1) One or more of the following:
   A) Certified by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) through the American Osteopathic Association (AOA); or
   B) Completion of a residency in emergency or osteopathic emergency medicine as prescribed by one of the above Boards; or
   C) Completion of a 12-month internship followed by 60 months plus 7,000 hours of hospital based emergency or osteopathic emergency medicine. 2,800 of the 7,000 hours must be completed within one 24-month period), and documentation of 50 hours of related continuing education for each complete year of practice; and
2) Completion of advanced cardiac life support and advanced trauma life support courses; and
3) For aircraft programs, completion of training covering inflight treatment modalities, altitude physiology, and infection; and
4) For watercraft programs, completion of training covering diving accident physiology and treatment, and drowning in cold, warm, fresh and salt water.

h) The Resource Hospital shall appoint a full-time EMS System Coordinator, who shall be responsible for coordinating the educational and functional aspects of the System, as described in the Program Plan. He or she shall be a registered professional nurse or EMT-P licensed in the State of Illinois, and meet at least the following qualifications:
   1) Be trained and knowledgeable in dysrhythmia identification and treatment,
   2) Have a diverse background in critical care, and
   3) Within one year after being appointed, complete in-field observation and/or participation on at least 10 ambulance runs at the highest level of service provided by the System.

i) The Resource Hospital shall appoint an EMS Administrative Director, who shall be responsible for administrative operations of the System as described in the Program Plan.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.330 EMS System Program Plan

An Emergency Medical Services (EMS) System Program Plan shall contain the following information:

a) The name, address and fax number of the Resource Hospital;
b) The names and resumes of the following persons:
   1) The EMS Medical Director,
   2) The Alternate EMS Medical Director,
   3) The EMS Administrative Director,
   4) The EMS System Coordinator;
c) The name, address and fax number of each Associate or Participating hospital (see subsection (i) of this Section);
d) The name and address of each ambulance provider participating within the EMS System;
e) A map of the EMS System's service area indicating the location of all hospitals and ambulance providers participating in the System;
f) Current letter(s) of commitment from the following persons at the Resource Hospital, which describe the commitment of the writer and his or her office to the development and ongoing operation of the EMS System, and which state the writer's understanding of and commitment to any necessary changes such as emergency department staffing and educational requirements:
   1) The Chief Executive Officer of the hospital,
   2) The Chief of the Medical Staff, and
   3) The Director of the Nursing Services;
g) A letter of commitment from the EMS Medical Director that describes the EMSMD's agreement to:
   1) Be responsible for the ongoing education of all System personnel,

including coordinating didactic and clinical experience;

2) Develop written standing orders (treatment protocols, standard operating procedures) to be used in the EMSMD's absence and certify that all involved personnel will be knowledgeable in emergency care and capable of providing treatment and using communications equipment once the program is operational;

3) Be responsible for supervising all personnel participating within the System, as described in the System Program Plan;

4) Develop or approve one or more ambulance emergency run reports (run sheets) covering all types of ambulance runs performed by System ambulance providers;

5) Ensure that the Department has access to all records, equipment and vehicles under the authority of the EMSMD during any Department inspection, investigation or site survey;

6) Notify the Department of any changes in personnel providing pre-hospital care in accordance with the EMS System Program Plan approved by the Department;

7) Be responsible for the total management of the System, including the enforcement of compliance with the System Program Plan by all participants within the System;

8) Ensure that a copy of the application for renewal (a form supplied by the Department) is provided to every EMT-B, EMT-I or EMT-P within the System who has not been recommended for relicensure by the EMS Medical Director; and

9) Be responsible for compliance with the provisions of Sections 515.400 and 515.410 of this Part;

h) A description of the method(s) of providing EMS services, which includes:

1) single vehicle response and transport;

2) dual vehicle response;

3) level of first response vehicle;

4) level of transport vehicle;

5) use of mutual aid agreements; and

6) informing the caller requesting an emergency vehicle of the estimated time of arrival when the vehicle response is estimated to be longer than six minutes from the time the dispatcher notifies the ambulance;

i) A letter of commitment from each Associate or Participating Hospital within the System, which includes the following:

1) Signed statements by the hospital's Chief Executive Officer, Chief of the Medical Staff and Director of the Nursing Service describing their commitments to the standards and procedures of the System;

2) A description of how the hospital will relate to the EMS System Resource Hospital, its involvement in the ongoing planning and development of the program, and its use of the education and continuing education aspects of the program;

3) Only at an Associate Hospital, a commitment to meet the System's

educational standards for ECRNs;

4) An agreement to provide exchange of all drugs and equipment with all pre-hospital providers participating in the System or other EMS system whose ambulances transport to them;

5) An agreement to use the standard treatment orders as established by the Resource Hospital;

6) An agreement to follow the operational policies and protocols of the System;

7) A description of the level of participation in the training and continuing education of pre-hospital personnel;

8) An agreement to collect and provide relevant data as determined by the Resource Hospital;

9) A description of the hospital's data collection and reporting methods and the personnel responsible for maintaining all data;

10) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;

11) If the hospital is a participant in another System, a description of how it will interact within both Systems and how it will ensure that communications interference as a result of this dual participation will be minimized; and

12) The names and resumes of the Associate Hospital EMS Medical Director and Associate Hospital EMS Coordinator;

j) A letter of commitment from each ambulance provider participating within the System, which indicates compliance with Section 515.810 of this Part;

k) Descriptions and documentation of each communications requirement provided in Section 515.400 of this Part;

l) The Program Plan shall consist of the EMS System Manual, which shall be provided to all System participants and shall include the following Sections:

1) Education and Training

A) Content and curricula of training programs for EMT, Emergency Medical Dispatcher, First Responder, Pre-Hospital RN, ECRN and Lead Instructor candidates, including:

i) Entrance and completion requirements;

ii) Program schedules;

iii) Goals and objectives;

iv) Subject areas;

v) Didactic requirements, including skills laboratories;

vi) Clinical requirements;

vii) Testing formats;

B) Training program for Prearrival Medical Instructions, if applicable, including:

i) Entrance and completion requirements;

ii) Description of course materials;

iii) Testing formats;

C) Continuing education for EMTs, Pre-Hospital RNs, ECRNs,

including:

i) System requirements (hours, types of programs, etc.);

ii) System program for System participants: types of activities covered (e.g., telemetry review, and morbidity and mortality conferences and protocols for enrollment and completion;

iii) Requirements for approval of academic course work;

iv) Didactic programs offered by the System;

v) Clinical opportunities available within the System;

vi) Record keeping requirements for participants, which must be maintained at the Resource Hospital;

D) Renewal Protocols

i) System examination requirements for EMTs, Pre-Hospital RNs, ECRNs;

ii) Procedures for renewal of Pre-Hospital RN and ECRN approvals;

iii) Submission of transaction cards for EMTs meeting renewal requirements;

iv) Providing Department renewal application forms to EMTs who have not met renewal requirements according to System records;

E) System participant education and information, including:

i) Distribution of System Manual amendments;

ii) In-services for policy and protocol changes;

iii) Methods for communicating updates in System and Regional activities, and other matters of medical, legal and/or professional interest;

iv) Locations of library/resource materials, forms, schedules, etc.;

F) A plan for phasing in Emergency Medical Dispatcher and First Responder registration requirements over a five-year period for Emergency Medical Dispatchers and First Responders who choose to be included in the Program Plan (see Sections 515.710 and 515.720 of this Part);

G) A System may require that up to one-half of the continuing education hours that are required toward relicensure, as determined by the Department, be earned through attendance at system-taught courses;

H) A didactic continuing education course that has received a State site code shall be accepted by the System, subject only to the requirements of subsection (b)(1)(C) of this Section;

2) Drugs and Equipment

A) A list of all drugs and equipment required for each type of System vehicle;

B) Procedures for obtaining replacements at System hospitals;

3) Personnel Requirements for EMTs

A) Minimum staffing for each type and level of vehicle;

B) Guidelines for EMT-patient interaction;

4) In-Field Protocols, including medical-legal policies but not limited to:

A) The Regional Standing Medical Orders;

B) System Standing Medical Orders as listed in Section 515.Appendix D;

C) Appropriate interaction with law enforcement on the scene;

D) When and how to notify a coroner or medical examiner;

E) Appropriate interaction with an independent physician/nurse on the scene;

F) The use of restraints;

G) Consent for treatment of minors;

H) Patient choice and refusal regarding treatment, transport, and/or destination;

I) The duty to perform all services without unlawful discrimination;

J) Offering immediate and adequate information regarding services available to victims of abuse, for any person suspected to be a victim of domestic abuse;

K) Patient abandonment;

L) Emotionally disturbed patients;

M) Patient confidentiality and release of information;

N) Durable power of attorney for health care; and

O) Do Not Resuscitate (DNR) Orders (see Section 515.380 of this Part);

5) Communications standards and protocols including:

A) The information contained in the System Program Plan relating to the requirements of Sections 515.410(a)(1), (2), (3) and (4) and 515.390(b) and (g) of this Part;

B) Protocols ensuring that physician direction and voice orders to EMS vehicle personnel and other hospitals participating in the System are provided from the operational control point of the Resource or Associate Hospital;

C) Protocols ensuring the voice orders via radio and using telemetry shall be given by or under the direction of the EMS Medical Director or the EMSMD's designee, who shall be either an ECRN, or physician; and

D) Protocols defining when an ECRN should contact a physician.

6) Quality improvement measures for both adult and pediatric patient care should be performed on a quarterly basis and be available upon Department request; ambulance operation and System training activities, including but not limited to monitoring training activities to ensure that the instructions and materials are consistent with United States Department of Transportation training standards for EMTs and Section 3.50 of the Act; unannounced inspections of pre-hospital services; and internal provider self-assessments;

7) Data collection and evaluation methods that include:

A) The process that will facilitate problem identification evaluation and monitoring in reference to patient care and/or reporting discrepancies from hospital and pre-hospital providers;
B) A copy of the pre-hospital reporting form;
C) A sample of the information and data to be reported to the Department summarizing System activity (see Section 515.350 of this Part);

8) Operational policies that delineate the respective roles and responsibilities of all providers in the System regarding the provision of emergency service, including:
A) Resource Hospital overrides (situations in which Associate Hospital orders are overruled by the Resource Hospital);
B) Infectious disease and disinfection procedures, including the policy on significant exposure;
C) Reporting and documentation of problems; and
D) Protocols for ILS/ALS System personnel to assess the condition of a patient being initially treated in the field by BLS personnel, for the purpose of determining whether a higher level of care is warranted and transfer of care of the patient to the ILS or ALS personnel is therefore appropriate. Such protocols shall include a requirement that neither the assessment nor the transfer of care can be initiated if it would appear to jeopardize the patient's condition, and shall require that such activities of the System personnel be done under the immediate direction of the EMS Medical Director or designee.

9) Any procedures regarding disciplinary and/or suspension decisions and the review of those decisions that the System has elected to follow in addition to those required by the Act;

10) Any System policies regarding abuse of controlled substances or conviction of a felony crime by System personnel whether on or off duty;

11) The responsibilities of the EMS Coordinator(s), as designated by the EMS Medical Director, including data evaluation, supervision of clinical, didactic and field experience training, and physician and nurse education as required; and

12) The responsibilities of the EMS Medical Director.

m) A written protocol for the bypassing of or diversion to a hospital, trauma center or regional trauma center other than the nearest hospital, regional trauma center or trauma center unless the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal. Section 3.30(c)(5) of the Act). The bypass policy should include a statement that for any life-threatening condition a patient may be transported to the closest

facility, whether or not that facility is on bypass. In addition, a hospital can declare a resource limitation, which is further outlined in the System Plan, for the following conditions:
1) There are no critical or monitored beds available in the hospital; or
2) An internal disaster occurs in the hospital;

n) A bypass may not be honored if three or more hospitals in a geographic area are on bypass and transport time by an ambulance to the nearest facility exceeds 15 minutes.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.340 EMS Medical Director's Course

a) An EMS Medical Director for an ILS or ALS level System who is appointed after the adoption of this Section shall submit to the Department proof of completion of a Department-approved EMS Medical Director's Course within six months after his or her date of appointment.

b) The following courses are approved by the Department:
1) American College of Emergency Physicians (ACEP) Principles of EMS Systems - A Course for Medical Directions.
2) Base Station Course National Association of Emergency Medical Services Physicians (NAEMSP).

c) The Department shall review requests for approval of other courses upon submission of the curriculum, along with the name, address and telephone number of the person or entity conducting the course. The Department shall approve the course if it meets the following criteria:
1) The course objectives are the same as the courses recommended in subsection (b) above; and
2) The course is taught by Board Certified emergency department physicians.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.350 Data Collection and Submission

a) A run report shall be completed by each vehicle service provider for every emergency pre-hospital or inter-hospital transport, and every non-emergency medical transport by a Department-licensed vehicle.
1) One copy shall be left with the receiving hospital emergency department, trauma center or health care facility before leaving this facility.
2) Each Resource Hospital shall designate or approve a single form to be used by all of its vehicle providers. It shall be either

the Department-issued scannable form, or a form that contains the minimum prescribed data elements listed in Section 515.Appendix E of this Part.

b) Each Resource Hospital shall submit a data report to the Department on March 1, June 1, September 1, and December 1 of each year, covering run report data from the preceding quarter. The report shall be in one of the following formats:

1) Copies of the Department-issued scannable run report form, or

2) A data diskette containing the prescribed data elements.

A) The data elements shall be in a format compatible with the Department's data base input specifications, and

B) Department review and approval of data format compatibility is required prior to submission.

c) When computer technology is available, each Resource Hospital shall develop and implement a mechanism for linking pre-hospital and inter-hospital run reports with emergency department, trauma center and admission records from the hospitals that receive emergency patients within the System. This mechanism shall facilitate tracking of case outcomes for purposes of internal quality control, medical study and improvement of both adult and pediatric patients.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.360 Approval of Additional Drugs and Equipment

a) All drugs and equipment, other than those covered by the United States Department of Transportation National Standard Curriculum for each EMT level of licensure, must be approved by the Department in accordance with subsections (b), (c) and (d) of this Section before being used in a System.

b) To apply for approval to add drugs and/or equipment, the EMSMD shall submit to the Department documentation covering the following:

1) Training program including a description of practical training for equipment and the number of contact hours;

2) A curriculum for each new drug or equipment, which includes at least the following (as applicable):

A) Usage,

B) Complications,

C) Adverse actions,

D) Equipment maintenance and use;

3) New written standing orders.

c) Upon receipt of the application from the System, the Director or his/her designee shall either approve the drug and/or equipment, approve the drug and/or equipment on a conditional basis, or disapprove the drug and/or equipment. The Director's/designee's decision shall be based on a review and evaluation of the documentation submitted under subsection (b) of this Section; the

application of technical and medical knowledge and expertise; consideration of relevant literature and published studies on the subject; and whether the drug and/or equipment has been reviewed or tested in the field. The Director may seek the recommendations of medical specialists and/or other professional consultants to determine whether to approve or disapprove the specific drug(s) and/or equipment.

d) The Director or designee shall consider whether the drugs and equipment may be used safely and with proper training by the pre-hospital care provider and shall disapprove any drugs and/or equipment that he/she finds are generally unsafe or dangerous in the pre-hospital care setting.

e) When a drug and/or equipment is approved on a conditional basis, the System shall submit to the Department, on a quarterly basis (January 1, April 1, July 1 and October 1) the following information:

1) Indications for use;

2) Number of times used;

3) Number and types of complications that occurred;

4) Outcome of patient after use of drug and/or equipment; and

5) Description of follow-up actions taken by the System on each case in which complications occurred.

f) When a death or complication that results in a deterioration of a patient's condition occurs, involving a drug and/or equipment approved on a conditional basis, the System shall notify the Department within three business days, followed by a written report of the situation submitted to the Department within 10 business days.

g) Failure of the System to submit the information required under subsection (e) of this Section shall be considered as a basis for withdrawal of approval of the drug or equipment on a conditional basis. Failure of the System to notify the Department as required under subsection (f) of this Section shall be considered as a basis for withdrawal of approval of the drug or equipment on a conditional basis.

h) The Director or designee shall evaluate the information submitted under subsection (e) of this Section and any notification required under subsection (f) of this Section. The Department will notify the System that a drug or equipment is disapproved and may no longer be performed on a conditional basis when the evaluation of the information submitted pursuant to this subsection (h) indicates that the safety of the drug or equipment has not been established for use in the pre-hospital setting.

i) An EMSMD shall not approve an EMT to use new drugs or equipment unless that EMT has completed the Department-approved training program and examination, and has demonstrated the required knowledge and skill to use that drug or equipment safely and effectively.

j) An EMSMD shall not be required to provide new drug or equipment training to System EMTs who will not be using the new drugs or equipment.

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(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.370 Automated Defibrillation

a) Automated Defibrillator Operation training is a mandatory component of the EMT-P training established by Section 515.320 of this Part. Separate course approval is therefore not necessary.

b) To be approved by the Department, an EMT-B or EMT-I Automated Defibrillator Operation course shall include the following:

1) A curriculum based on Section 9 of the United States Department of Transportation, Emergency Medical Technician-Intermediate: National Standard Curriculum;

2) A requirement that the EMT-B or EMT-I shall pass both a written and a practical examination as a condition of completing the course. The examinations shall be developed and evaluated by the EMS Medical Director or designee and shall be designed to measure the EMT's knowledge and skills to operate an automated defibrillator safely and effectively.

c) A System may include the course in Automated Defibrillator Operation as part of an initial EMT-B or EMT-I license training program or may offer such training to persons already licensed as an EMT-B or EMT-I.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.380 Do Not Resuscitate (DNR) Policy

a) A System shall develop a DNR policy for use by System personnel. The policy shall be implemented only after it has been reviewed and approved by the Department, in accordance with the requirements of this Section. For purposes of this Section, DNR refers to the withholding of cardiopulmonary resuscitation (CPR); electrical therapy to include pacing, cardioversion and defibrillation; tracheal intubation and manually or mechanically assisted ventilations, unless otherwise stated on the DNR Order.

b) The policy shall include, but not be limited to, specific procedures and protocols for cardiac arrest DNR situations arising in long-term care facilities, with hospice and home care patients, and with patients who arrest during inter-hospital transfers or transportation to or from home.

c) The policy shall include specific procedures and protocols for withholding CPR in situations where explicit signs of biological death are present, e.g., decapitation, rigor mortis without profound hypothermia, profound dependent lividity, or the patient has been declared dead by a coroner or the patient's physician. The policy shall include recording such information on the run sheet and requesting the physician or coroner to sign the run sheet (if

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applicable).

d) For situations not covered by subsection (c) of this Section, the policy shall require that resuscitative procedures be followed unless a valid DNR Order is present.

e) A valid DNR Order shall consist of a written document, which has not been revoked, containing at least the following information:

1) Name of the patient;

2) Name and signature of attending physician;

3) Effective date;

4) The words "Do Not Resuscitate";

5) Evidence of consent - either:

A) signature of patient; or

B) signature of legal guardian; or

C) signature of durable power of attorney for health care agent; or

D) signature of surrogate decision-maker.

f) A living will by itself cannot be recognized by pre-hospital care providers.

g) Revocation of a written DNR Order shall be made only in one or more of the following ways:

1) The Order is physically destroyed or verbally rescinded by the physician who signed the Order; or

2) The Order is physically destroyed or verbally rescinded by the person who gave written consent to the Order.

h) A System's DNR policy shall require System personnel to make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid DNR Order.

i) The policy shall describe the roles of the on-line medical control physician and BCRN in DNR situations.

j) The policy shall state which System ambulance personnel are authorized to respond to a valid DNR Order (EMT-P, EMT-I, EMT-B, Pre-hospital RN).

k) The policy shall cross-reference the System's coroner notification policy.

l) The policy shall describe the System's program for educating System personnel concerning the policy.

m) The policy shall identify the quality assurance measures specific to this policy, including the methods and periods of review, and the submission of a yearly report to the Department indicating issues or problems that have been identified and the System's responses to those issues or problems.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.390 Minimum Standards for Continuing Operation

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a) The Resource Hospital and all System participants shall comply with the terms of the EMS System Program Plan, the System Manual, their respective letters of commitment and any applicable provisions of the Act or this Part.

b) All EMS System personnel and ambulances are responsible for and shall maintain their certifications, licenses and approvals.

c) In accordance with Section 515.460 of this Part, the Department may suspend, revoke or refuse to renew the approval of any EMS System when its findings show that the System is in violation of one or more of the requirements of the Act and this Part.

1) Such suspension, revocation or refusal to renew shall be preceded by notice and an opportunity for a hearing served upon the EMS Medical Director by certified mail or personal service.

2) The notice shall set forth the reasons for the proposed suspension or revocation and shall afford the EMS Medical Director 15 days from the date of receipt to make a written request for an administrative hearing. The EMSMD's failure to file a written request for a hearing within 15 days shall be considered a waiver of the System's right to a hearing on the proposed suspension, revocation, or refusal.

3) All hearings shall be conducted in accordance with the Department's Rules of Practice and Procedure for Administrative Hearings (77 Ill. Adm. Code 100).

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.400 General Communications

a) All radios used by ambulance services shall:

1) Have two-way ambulance-to-hospital communications capability on frequencies assigned by the Department;

2) Use channel and tones assigned by the Department; and

3) Use unit identifier numbers or other descriptive means of identification locally acceptable.

b) All radio communications systems will require preliminary coordination with and recommendations from the Department's communication personnel.

c) All pre-hospital care providers must provide information relative to the mechanism used for consumer access and dispatch of emergency vehicles within their respective service area.

d) All hospitals participating in an EMS Plan or receiving emergency patients by ambulances must:

1) Have two-way ambulance-to-hospital communications capability on a frequency determined and assigned by the Department; and

2) Have two-way hospital-to-hospital communications capability.

e) The use of cellular telephone technology is permitted provided that:

1) The ambulance also has VHF or UHF radio back-up on a frequency

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assigned by the Department; and

2) The permission of the EMS Resource Hospital is obtained.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.410 EMS System Communications

a) The System's communications plan shall be submitted for approval to the Department's EMS Communications staff, and shall include the following in accordance with 47 CFR 90 (1994):

1) A listing of access numbers of Emergency Medical Services, including a description of plans to use or to implement a "911" System or Central Medical Emergency Dispatch (CMED) if or when available and a list of agencies involved;

2) A description of communications interface with existing Systems;

3) A description of plans to handle hospital-to-hospital communications;

4) A complete and detailed communications equipment description;

5) A general description of ultra-high frequency (UHF) or cellular telephone and back-up radio capabilities, such as very high frequency (VHF) or UHF radio, including Resource and Associate Hospital interconnections and control functions if any exist;

6) A general description of paramedic input telephones, including Resource and Associate Hospital interconnections if any exist;

7) A general description of EMS vehicle dispatch communications, including areas covered, mutual aid agreements, radio and telephone capabilities, including radio channels used (i.e., 155.220MHz) and present and future 911 involvement;

8) All mobile and portable communications equipment to be used by EMS System personnel;

9) A detailed block diagram sketch or sketches showing all transmitters, receivers, antennas, control consoles, electrocardiogram (EKG) demodulators, patient monitor equipment, recorders, telephones, and couplers, with signal flow lines;

10) Radio equipment specifications, including effective radiated power ERP), antenna height, ground heights, antenna pattern, antenna direction, channels used, continuous tone-controlled squelch system tones, and digital dial numbers;

11) Modes of operation such as half-duplex and multiplex;

12) Radio coverage maps showing locations of all transmitting and receiving equipment and control points;

13) A general discussion concerning radio interference and steps taken to minimize it (i.e., the use of only short EKG transmission, thus allowing several EMS units to use one channel, minimizing ERP and antenna height);

14) Copies of Federal Communications Commission (FCC) licenses or

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application; and

15) A narrative description of the System's plans for informing the community of the EMS System program development, how citizens can gain access, and the ongoing operation of the System.

b) EMS telecommunications equipment shall be configured to allow the EMS Medical Director, or designee, to monitor all vehicle to hospital transmissions and hospital-to-vehicle transmissions within the System.

c) Resource and Associate Hospitals shall have an operational control point for a Medical Emergency Communications of Illinois (MERCI) VHF/UHF base station, telemetry receiving and monitoring and any Associate to Resource Hospital intercom lines.

d) Physician direction shall be provided from the operational control point of an approved Resource or Associate Hospital. All medical orders/direction given shall be taped.

e) Telecommunications equipment necessary to fulfill the requirements of this Part shall be staffed and maintained 24 hours every day, including VHF and UHF base stations and their required telephone equipment.

f) EMS System personnel shall be capable of properly operating their respective communications equipment.

g) All telecommunications equipment shall be maintained to minimize breakdowns. Procedures shall be established to provide immediate action to be taken by operating personnel to ensure rapid restoration in case breakdowns do occur.

h) Written protocols shall describe communications procedures for operation of the System, all base station control points, and field units. These protocols shall contain provisions for limiting the time of individual radio transmissions to include only necessary information transfer (i.e., short telemetry strips). Mobile base control points and mobile units shall have an easily accessible copy of the protocols pertaining to their stations.

i) The Department shall approve channel assignments, ERP, antenna height and locations, and tones in new Systems to ensure radio coverage in approved program service areas without causing interference in existing Systems.

j) The Department shall monitor and may require modifications in channel assignments, tones, antenna height and locations, and ERP to correct documented radio interference problems.

(Source: Added at 10 Ill. Reg. _____, effective _____)

Section 515.420 System Participation Suspensions

a) *An EMS Medical Director may suspend from participation within the System any individual, individual provider or other participant considered not to be meeting the requirements of the Program Plan of that approved EMS System.* (Section 3.40(a) of the Act)

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b) Except as allowed in subsection (1) of this Section, the EMS Medical Director shall provide the individual, individual provider or other participant with a written explanation of the reason for the suspension; the terms, length, and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review Board shall be provided.

c) Failure to request a hearing within 15 days shall constitute a waiver of the right to a Local System Review Board hearing.

d) *The Resource Hospital shall designate the local System review board,* consisting of at least three members, one of whom is an Emergency Department physician with knowledge of EMS, one of whom is an EMT and one of whom is of the same professional category as the individual, individual provider or other participant requesting the hearing. (Section 3.40(e) of the Act)

e) The hearing shall commence as soon as possible but at least within 21 days after receipt of a written request. *The EMS Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of that hearing and thereafter prepare a transcript of the proceedings. The transcript, all documents or materials received as evidence during the hearing and the local System review board's written decision shall be retained in the custody of the EMS System. The System shall implement a decision of the local System review board unless that decision has been appealed to the State Emergency Medical Services Disciplinary Review Board in accordance with the Act and* this Part. (Section 3.40(e) of the Act)

f) The Local System Review Board shall state in writing its decision to affirm, modify or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the EMS Medical Director and the individual, individual provider or other participant who requested the hearing within five business days after the conclusion of the hearing.

g) The transcripts, all documents or materials received as evidence during the hearing and the Local System Review Board's written decision shall be retained in the custody of the EMS System.

h) The EMS Medical Director shall notify the Department, in writing, within five business days after the Board's decision to either uphold, modify or reverse the EMS Medical Director's suspension of an individual, individual provider or participant. The notice shall include a statement detailing the duration and grounds for the suspension.

i) *If the local System review board affirms or modifies the EMS Medical Director's suspension order,* the individual, individual provider or other participant *shall have the opportunity for a review of the local board's decision of the State EMS Disciplinary Review Board.* (Section 3.40(b)(1) of the Act)

j) *If the Local System Review Board reverses or modifies the EMS Medical Director's suspension order, the EMS Medical Director shall have the*

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opportunity for review of the local board's decision by the State EMS Disciplinary Review Board. (Section 3.40(b)(2) of the Act)

k) Requests for review by the State EMS Disciplinary Review Board shall be submitted in writing to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, within 10 days after receiving the local board's decision or the EMS Medical Director's suspension order, whichever is applicable. A copy of the Board's decision or the suspension order shall be enclosed. (Section 3.45(h) of the Act)

l) An EMS Medical Director may immediately suspend an individual, individual provider or other participant if he or she finds that the information in his or her possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the EMS Medical Director which states the length, terms and basis for the suspension. (Section 3.40(c) of the Act)

1) Within 24 hours following the commencement of the suspension, the EMS Medical Director shall deliver to the Department, by messenger or telefax, a copy of the suspension order and copies of any written materials which relate to the EMS Medical Director's decision to suspend the EMT or provider.

2) Within 24 hours following the commencement of the suspension, the suspended EMT or provider may deliver to the Department, by messenger or telefax, a written response to the suspension order and copies of any written materials which the EMT or provider feels relate to that response.

3) Within 24 hours following receipt of the EMS Medical Director's suspension order or the EMT or provider's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending the EMT's or provider's opportunity for hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The Director or the Director's designee shall issue this determination to the EMS Medical Director, who shall immediately notify the suspended EMT or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee. (Section 3.40(c) of the Act.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.430 Suspension, Revocation and Denial of Licensure of EMTs

In accordance with Section 515.160 of this Part, the Director, after providing notice and an opportunity for an administrative hearing to the applicant or

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licensee, shall deny, suspend or revoke a license or refuse to relicense any person as an EMT-B, EMT-I or EMT-P in any case in which he or she finds that there has been a substantial failure to comply with the provisions of the Act or this Part. Such findings must show one or more of the following:

a) The EMT has not met continuing education or relicensure requirements as prescribed by the Department in this Part (Section 3.50(d)(8)(A) of the Act);

b) The EMT has failed to maintain proficiency in the level of skills for which he or she is licensed (Section 3.50(b)(8)(B) of the Act);

c) The EMT, during the provision of medical services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public (Section 3.50(d)(8)(C) of the Act) (e.g., use of alcohol or illegal drugs while on duty, verbal or physical abuse of a patient, or misrepresentation of licensure status);

d) The EMT has failed to maintain or has violated standards of performance and conduct as prescribed by the Department in this Part or his or her EMS System's Program Plan (Section 3.50(d)(8)(D) of the Act);

e) The EMT is physically impaired to the extent that he or she cannot physically perform the skills and functions for which he or she is licensed, as verified by a physician, unless the person is on inactive status pursuant to this Part (Section 3.50(d)(8)(E) of the Act);

f) The EMT is mentally impaired to the extent that he or she cannot exercise the appropriate judgment, skill and safety for performing the functions for which he or she is licensed, as verified by a physician, unless the person is an EMT-I or EMT-P on inactive status pursuant to this Part (Section 3.50(d)(8)(F) of the Act);

g) The EMT has violated the Act or this Part (Section 3.50(d)(8)(G));

h) The EMT has demonstrated medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care; or

i) The EMT's license has been revoked, denied or suspended by the Department.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.440 State Emergency Medical Services Disciplinary Review Board

a) The Governor shall appoint a State Emergency Medical Service Disciplinary Review Board in accordance with Section 3.45 of the Act. (Section 3.45(a) of the Act)

b) The Board shall regularly meet on the first Tuesday of every month, unless no requests for review have been submitted. Additional meetings of the Board shall be scheduled as necessary to insure that a request for direct review of an immediate suspension order is scheduled within 14 days after the Department receives the request for

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review or as soon thereafter as a quorum is available. The Board shall meet in Springfield or Chicago, whichever location is closer to the majority of the members or alternates attending the meeting. (Section 3.45(g) of the Act)

c) At its regularly scheduled meetings, the Board shall review requests which have been received by the Department at least 10 working days prior to the Board's meeting date. Requests for review which are received less than 10 working days prior to a scheduled meeting shall be considered at the Board's next scheduled meeting, except that requests for direct review of an immediate suspension order may be scheduled up to 3 working days prior to the Board's meeting date. (Section 3.45(i) of the Act)

d) A quorum shall be required for the Board to meet which shall consist of 3 members or alternates, including the EMS Medical Director or alternate and the member or alternate from the same professional category as the subject of the suspension order. At each meeting of the Board, the members or alternates present shall select a Chairperson to conduct the meeting. Section 3.45(j) of the Act)

e) Meetings of the State EMS Disciplinary Review Board shall be conducted in closed session. Department staff may attend for the purpose of providing clerical assistance. No other persons may be in attendance except for the parties to the dispute being reviewed by the Board and their attorneys, unless by request of the Board. Meetings of the Board shall be exempt from the provisions of the Open Meetings Act. (Section 3.45(k) of the Act)

f) The Board shall review the transcript, evidence and written decision of the local review board or the written decision and supporting documentation of the EMS Medical Director, whichever is applicable, along with any additional written or verbal testimony or argument offered by the parties to the dispute. (Section 3.45(l) of the Act)

g) At the conclusion of its review, the Board shall issue its decision and the basis for its decision on a form provided by the Department, and shall submit to the Department its written decision together with the record of the local system review board. The Department shall promptly issue a copy of the Board's decision to all affected parties. The Board's decision shall be binding on all parties. (Section 3.45(m) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

Section 515.500 Emergency Medical Technician-Basic Training

a) Applications for approval of EMT-B Training Programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, lead instructor's name and address, dates of the training program, and name and signature of EMS Medical Director.

b) Applications for approval, including a copy of the class schedule and course syllabus, shall be submitted at least 60 days in advance of the first scheduled class. Included with the application shall be a description of the clinical requirements, textbook being used and passing score for the class.

c) The EMS Medical Director shall attest on the application form that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum (minimum sections shall include #1 through #7 of the National Curriculum for EMT Basic), and that all instructors are knowledgeable in the material and capable of instructing at the EMT-B level.

d) The EMT-B training program shall designate an EMS Lead Instructor who shall be responsible for the overall management of the training program and shall be approved by the Department based on requirements of Section 515.700.

e) Any change excluding an emergency change (e.g., weather or instructor illness) in the EMT-B training program's Medical Director or EMS Lead Instructor shall require an amendment to be filed with the Department.

f) Questions for all quizzes and tests to be given during the EMT-B training program shall be prepared by the EMS Lead Instructor and available upon the Department's request.

g) Each approved training program shall submit a student roster within 10 days after the first class as well as a student roster indicating successful or unsuccessful completion within 10 days after the last class. An examination roster shall be submitted to the Department prior to the deadline date for examination.

h) All approved programs shall maintain class and student records for seven years, and these shall be made available to the Department upon request.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.510 Emergency Medical Technician-Intermediate Training

a) An EMT-I training program shall be conducted only by an EMS System or a community college under the direction of the EMS System.

b) Applications for approval of EMT-I Training Programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, not limited to, name of applicant, agency and address, type of training program, lead instructor's name and address, dates of training program, and names and signatures of the EMS Medical Director and EMS System Coordinator.

c) Applications for approval, including a copy of the class schedule and course syllabus, shall be submitted at least 60 days in advance of the

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first scheduled class.

d) The EMS Medical Director of the EMS System shall attest on the application form that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum. Minimum sections shall include #1 through #8.

e) The EMT-I training program shall be under the direction of the EMS Medical Director and the EMS System Coordinator.

f) The EMS System shall designate an EMS Lead Instructor, who shall be approved by the Department based on the requirements of Section 515.700.

g) The EMS Lead Instructor shall be an EMT-I, an EMT-P, a Registered Nurse or a physician and shall have four years of experience in emergency care as a provider and two years of teaching experience in a classroom setting.

h) Any change excluding an emergency change (e.g., weather or instructor illness) in the EMT-I training program's EMS Medical Director, EMS System Coordinator and/or EMS Lead Instructor shall require an amendment to be filed with the Department.

i) A candidate for an EMT-I training program must have a current Illinois EMT-B license.

j) Before a candidate is accepted into the program, documentation must be submitted that an EMS System vehicle will be available to accommodate field experience.

k) Each approved training program shall submit a student roster within 10 days after the first class.

l) After an EMT-I candidate has completed and passed all components of the training program, and passed the Department's exam or the National Registry examination, the EMSMD shall submit to the Department a transaction card (Form No. IL 482-0837) concerning that individual.

m) All approved programs shall maintain class and student records for seven years, and these shall be made available to the Department upon request.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.520 Emergency Medical Technician-Paramedic Training

a) An EMT-P training program shall be conducted only by an EMS System or a community college under the direction of the EMS System.

b) Applications for approval of EMT-P training programs shall be filed with the Department on forms prescribed by the Department. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, dates of training program, and names and signatures of the EMS Medical Director and EMS System Coordinator.

c) Applications for approval, including a copy of the class schedule and course syllabus, shall be submitted at least 60 days in advance of the

first scheduled class.

d) The EMS Medical Director of the EMS System shall attest on the application form that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum. The EMT-P training program shall include all components of the National Standard Curriculum.

e) The EMT-P training program's Lead Coordinators shall be the EMS Medical Director and the EMS System Coordinator.

f) Any change excluding an emergency change (e.g., weather or instructor illness) in the EMT-P training program's EMS Medical Director and/or EMS System Coordinator shall require an amendment to be filed with the Department.

g) A candidate for an EMT-P training program must have a current Illinois EMT-B or EMT-I license.

h) Before a candidate is accepted into the program, documentation must be submitted that an EMS System vehicle will be available to accommodate field experience and internship needs.

i) Each approved training program shall submit a student roster within 10 days after the first class.

j) After an EMT-P candidate has completed and passed all components of the training program, and passed the Department or National Registry examination, the EMSMD shall submit to the Department a transaction card (Form No. IL 482-0837) concerning that individual.

k) All approved programs shall maintain class and student records for seven years, and these shall be made available to the Department upon request.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.530 EMT Testing and Fees

a) All EMT-B candidates shall hold a high school diploma or high school equivalency certificate and be 18 years of age or older to be tested for licensure.

b) After completion of an approved training program, candidates shall take a written examination. The candidate shall have the choice of taking either the National Registry of Emergency Medical Technicians examination or the Department's examination. The Department's examination is based on the United States Department of Transportation National Standard Curriculum and is equivalent to the National Registry Examination.

c) The Department or designee shall administer the State written examination for EMT-B, EMT-I and EMT-P licensure. Candidates who elect to take the National Registry of Emergency Medical Technicians examination in lieu of the state examination shall be responsible for making their own arrangements with the National Registry.

d) A failure rate per class of 25 percent or greater on the licensure

examination shall require that the particular training program be reevaluated by the Department at least 60 days before the start of the next class.

e) The candidate shall retake the training program if he/she fails to achieve a passing grade on three successive examinations within 12 months after sitting for the examination for the first time.

f) When a candidate elects to take the State examination or the National Registry's examination, the candidate must pass that particular testing procedure. A candidate will not be allowed to take the alternate examination after failure to achieve a passing grade.

g) A candidate making application for the Department's written examination for licensure shall include a certified check or money order made payable to the Department (personal checks or cash will not be accepted) for:

1) EMT-B examination - $20;
2) EMT-I examination - $30; or
3) EMT-P examination - $40.

h) Failure to appear for the examination on the scheduled date, at the time and place specified, shall result in the forfeiture of the examination fee.

i) If a candidate does not achieve a passing grade on the written examination, the fee for the retest is the same as for initial examination.

j) All fees submitted for licensure examinations are not refundable.

k) Fees paid to the Department for testing shall be returned to the Resource Hospital serving the System in which the candidate trained.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.540 EMT Licensure

a) To be licensed by the Department as an EMT-B an individual must:
1) Pass either the National Registry of Emergency Medical Technicians examination or the Department's EMT-B examination.
2) Be functioning within a State-approved EMS System providing basic life support services, as verified by that System's EMS Medical Director.

b) To be licensed by the Department as an EMT-I, an individual must:
1) Pass either the National Registry of Emergency Medical Technicians examination or the Department's EMT-I examination.
2) Be functioning within a State-approved EMS System providing intermediate life support services, as verified by that System's EMS Medical Director.

c) To be licensed by the Department as an EMT-P an individual must:
1) Pass either the National Registry of Emergency Medical Technicians examination or the Department's EMT-P examination.
2) Be functioning within a State-approved EMS System providing

advanced life support services, as verified by that System's EMS Medical Director.

d) An EMT license will specify the level of licensure, i.e., EMT-B, EMT-I OR EMT-P, and will be effective for a period of four years.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.550 Scope of Practice - Licensed EMT

a) *Any person licensed as an EMT-B, EMT-I or EMT-P shall perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in this Part, and the requirements of the EMS System in which he or she practices, as contained in the approved Program Plan for that System.* (Section 3.55 (a) of the Act)

b) *A person currently licensed as an EMT-B, EMT-I, or EMT-P may only practice as an EMT or utilize his or her EMT license in pre-hospital or inter-hospital emergency care settings or non-emergency medical transport situations, under the written or verbal direction of the EMS Medical Director. For purposes of this Section, a "pre-hospital emergency care setting" may include a location, that is not a health care facility, which utilizes EMTs to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMT's level of care, and the protocols of the EMS Systems, and shall operate only with the approval and under the direction of the EMS Medical Director.* (Section 3.55(b) of the Act)

c) *This* does not prohibit an *EMT-B, EMT-I, or EMT-P from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS Medical Director. This also* does not prohibit an *EMT-B, EMT-I, or EMT-P from seeking credentials other than his or her EMT license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer.* (Section 3.55(b) of the Act)

d) *A student enrolled in a Department-approved emergency medical technician program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the System and the Department, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified registered professional nurse or a qualified EMT, only when authorized by the EMS Medical Director.* Section 3.55(d) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.560 EMT-B Continuing Education

a) Continuing education classes, seminars, clinical time, workshops or other types of programs shall be approved by the Department before being offered to EMT-Bs. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for EMT-Bs. Upon approval, the Department will issue a site code to the class, seminar, workshop or program.

c) An EMT-B shall be responsible for submitting written proof of continuing education attendance to the EMS System Coordinator or the Department Regional EMS Coordinator.

d) The EMS System Coordinator or Department Regional EMS Coordinator shall be solely responsible for verifying whether specific continuing education hours have been earned by the EMT-B.

e) An EMT-B shall be responsible for maintaining copies of all documentation concerning continuing education programs that he or she has completed.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.570 EMT-I Continuing Education

a) Didactic continuing education classes, seminars or other types of programs shall be approved by the Department before being offered to EMT-Is. An application for approval shall be submitted to the Department by an EMS Medical Director, on a form prescribed and furnished by the Department, at least 60 days prior to the scheduled event.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for Intermediates. Upon approval, the Department will issue a site code to the class, seminar or program.

c) An EMS System may apply to the Department for a single System Site Code to cover didactic continuing education activities conducted by the System solely for System EMT-Is (e.g., telemetry review at the Resource Hospital, morbidity and mortality conferences, preceptor orientation, review of System education materials). Activities conducted under the System Site Code shall not require individual approval by the Department.

d) The EMSMD of the EMS System in which the EMT-I functions shall be responsible for determining whether a particular State-approved

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didactic continuing education program is acceptable for credit within the System.

e) An EMT-I shall be responsible for submitting written proof of didactic continuing education attendance to the EMS System Coordinator, in the manner prescribed by the System Program Plan.

f) The EMS System Coordinator or EMS Medical Director of the EMS System in which an EMT-I primarily functions shall be solely responsible for verifying whether specific continuing education hours have been earned by the EMT-I.

g) An EMS System that requires clinical continuing education shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted and verified.

h) An EMT-I shall be responsible for maintaining copies of all documentation concerning continuing education programs or activities that he or she has completed.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.580 EMT-P Continuing Education

a) Didactic continuing education classes, seminars or other types of programs shall be approved by the Department before being offered to EMT-Ps. An application for approval shall be submitted to the Department by an EMS Medical Director, on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for Paramedics. Upon approval, the Department will issue a site code to the class, seminar or program.

c) An EMS System may apply to the Department for a single System Site Code to cover didactic continuing education activities conducted by the System solely for System EMT-Ps (e.g., telemetry review at the Resource Hospital, morbidity and mortality conferences, preceptor orientation, review of System educational materials). Activities conducted under the System Site Code shall not require individual approval by the Department.

d) The EMSMD of the EMS System in which the EMT-P functions shall be responsible for determining whether a particular State-approved didactic continuing education program is acceptable for credit within that System.

e) An EMT-P shall be responsible for submitting written proof of didactic continuing education attendance to the EMS System Coordinator, in the manner prescribed by the System Program Plan.

f) The EMS System Coordinator or EMS Medical Director of the EMS System

in which an EMT-P primarily functions shall be solely responsible for verifying whether specific continuing education hours have been earned by the EMT-P.

g) An EMS System that requires clinical continuing education shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted and verified.

h) An EMT-P shall be responsible for maintaining copies of all documentation concerning continuing education programs or activities that he or she has completed.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.590 EMT License Renewals

a) To be relicensed as an EMT:

1) The licensee shall file an application for renewal with the Department on a form prescribed by the Department at least 30 days prior to the license expiration date.

A) The submission of a transaction card (Form No. IL 482-0837) by the EMS Medical Director will satisfy the renewal application requirement for a licensee who has been recommended for relicensure by the EMS Medical Director.

B) A licensee who has not been recommended for relicensure by the EMS Medical Director must independently submit to the Department an application for renewal. The EMS Medical Director shall provide the licensee with a copy of the appropriate form to be completed.

2) A written recommendation signed by the EMS Medical Director must be provided to the Department regarding completion of the following requirements:

A) One hundred twenty hours of continuing education, seminars and workshops, addressing both adult and pediatric care. The System shall define in the Program Plan the number of continuing education hours to be accrued each year for relicensure. No more than 25 percent of those hours may be in the same subject.

B) For EMT-B and EMT-I, a refresher course or Basic Trauma Life Support (BTLS) or Pre-hospital Trauma Life Support (PHTLS), to be successfully completed during the last two years of the relicensure period. Hours accried for the refresher course, BTLS or PHTLS shall be included in the required 120 hours of continuing education.

C) Any System continuing education requirements for an EMT approved to operate an automated defibrillator shall be included in the required 120 continuing education hours.

D) A current CPR completion card that covers:

i) Adult one-rescuer CPR,

ii) Adult foreign body airway obstruction management,

iii) Pediatric one-rescuer CPR,

iv) Pediatric foreign body airway obstruction management, and

v) Adult two-rescuer CPR.

E) Functioning within a State-approved EMS System providing the licensed level of life support services as verified by that System's EMS Medical Director.

b) Composition of refresher training programs, continuing education programs and qualifications of instructors shall be submitted to the Department for approval not less than 60 days prior to the scheduled event. Program approval will be granted provided the program is conducted in accordance with guidelines of the Department of Transportation's National Standard Curriculum for EMTs and contains material relevant to that level of licensure. Qualifications of instructors shall be consistent with Section 515.700.

c) If the EMS Medical Director does not recommend relicensure, he/she shall submit all reasons for denial in writing to the EMT and the Department.

d) The license of an EMT who has failed to file an application for renewal shall terminate on the day following the expiration date shown on the license.

e) At any time prior to the expiration of the current license, an EMT-I or EMT-P may revert to the EMT-B status for the remainder of the license period. The EMT-I or EMT-P must make this request in writing to the Department. To relicense at the EMT-B level, the individual must meet the EMT-B requirements for relicensure.

f) An EMT-I or EMT-P who has reverted to EMT-B status may be subsequently relicensed as an EMT-I or EMT-P, upon the recommendation of an EMS Medical Director who has verified that the individual's knowledge and clinical skills are at an active EMT-I or EMT-P level, and that the individual has completed any retraining, education or testing deemed necessary by the EMSMD for resuming EMT-I or EMT-P activities.

g) Any EMT whose license has expired for a period of more than 60 days shall be required to reapply for licensure, complete the training program and pass the test, and pay the fees as required for initial licensure (see subsection (i) below).

h) The Department shall require the licensee to certify on the renewal application form, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Section 10-65 of the Illinois Administrative Procedure Act (5 ILCS 100/10-65).

i) An EMT whose license has expired may, within 60 days after licensure expiration, submit all relicensure material as required in this Part and a fee of $50 in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the EMT, the

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Department will relicense the EMT.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.600 EMT Inactive Status

a) Prior to the expiration of the current license, an EMT may request to be placed on inactive status. The request shall be made in writing to the EMS Medical Director. The EMS Medical Director will apply to the Department in writing and request that the EMT be placed on inactive status. The application shall contain the following information:
   1) Name of individual;
   2) Date of licensure;
   3) Licensure type, i.e., EMT-B, EMT-I or EMT-P;
   4) EMT identification number;
   5) Circumstances requiring inactive status; and
   6) A statement that relicensure requirements have been met by the date of the application for inactive status.

b) The Department will review requests for inactive status. The Department shall notify the EMS Medical Director in writing of its decision based on subsection a) of this Section.

c) If the request for inactive status is granted, the EMSMD shall forward the EMT's license to the Department.

d) For the EMT to return to active status, the EMS Medical Director must make application to the Department. The application must be in writing and include a statement that the EMT has been examined (physically and mentally) and found capable of functioning within the EMS System; that the EMT's knowledge and clinical skills are at the active EMT level for that individual's license; and that the EMT has completed any refresher training deemed necessary by the EMSMD and approved by the Department. If the inactive status was based on a temporary disability, the EMSMD shall also verify that the disability has ceased.

e) During inactive status, the EMT shall not function as an EMT, at any level.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.610 EMT Reciprocity

a) EMTs from other states who wish to function in Illinois as an Emergency Medical Technician may apply to the Department for licensure by reciprocity.

b) Such application shall be in writing and contain the following information:
   1) Proof of current registration by the state in which he/she currently functions and written verification from that state or current registration with the National Registry of Emergency Medical Technicians and written verification thereof;
   2) A written statement of satisfactory completion of a training program that meets or exceeds the requirements of the Department as set forth in this Part;
   3) A letter of recommendation from the EMS Medical Director of the EMS System in which the individual will function including a statement that all System requirements have been met; and
   4) A current CPR completion card.

c) The Department will review requests for reciprocity to determine compliance with the applicable provisions of this Part. Continuing education hours from the state of current licensure will be prorated based on the expiration date of the current license.

d) Individuals who meet the requirements for licensure by reciprocity will be State licensed consistent with the expiration date of their current license but not to exceed a period of four years.

e) Following licensure by reciprocity, the individual must comply with the requirements of this Part for relicensure.

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

Section 515.700 EMS Lead Instructor

a) *All education, training and continuing education courses for EMT-B, EMT-I, EMT-P, Pre-Hospital RN, SCRN, First Responder and Emergency Medical Dispatcher* shall be coordinated by at least one approved *EMS Lead Instructor. A program may use* more than one *EMS Lead Instructor. A single EMS Lead Instructor may simultaneously coordinate more than one program or course.* Section 3.55(o)(5) of the Act)

b) To apply to take the EMS Lead Instructor's examination, the candidate shall submit:
   1) Documentation of experience and education in accordance with subsection (c) of this Section;
   2) A fee of $50 in the form of a money order or certified check made payable to the Department (cash or a personal check will not be accepted);
   3) A letter from the EMS Medical Director saying he/she will approve the course conducted by the candidate;
   4) An EMS Lead Instructor application form prescribed by the Department, which shall include, but not be limited to, name, address, and resume.

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c) An EMS Lead Instructor shall meet at least the following minimum experience and education requirements:
   1) A current license as an EMT-B, EMT-I, EMT-P, RN or physician;
   2) A minimum of four years of experience in pre-hospital emergency care;
   3) At least two years of documented teaching experience;
   4) Documented classroom teaching experience, i.e., BTLS, PHTLS, CPR, Pediatric Advanced Life Support (PALS);
   5) Documented successful completion of the Illinois EMS Instructor Education Course or equivalent to the National Standard Curriculum for EMS Instructors.

d) Upon the applicant's completion of the EMS Lead Instructor examination with a score of at least 80 percent, the Department will approve the individual as an EMS Lead Instructor. The approval will be valid for four years.

e) An individual who prior to August 1, 1995, coordinated education, training and continuing education courses for pre-hospital providers may petition the Department for conditional approval as an EMS Lead Instructor. Conditional approval will be granted until July 1, 2000, by which date the individual must successfully complete the EMS Lead Instructor examination. Individuals petitioning for conditional approval must submit the following to the Department:
   1) A resume including documentation of experience and education in accordance with subsection (c) of this Section.
   2) A listing of all relevant programs coordinated from January 1, 1991 to present.
   3) A letter of support from an EMS Medical Director indicating that the individual has satisfactorily coordinated programs for the EMS System at any time between August 1, 1995, and the effective date of this Part.
   4) An EMS Lead Instructor application form prescribed by the Department, which shall include, but not be limited to name, address.

f) To renew approval for another four-year period, the EMS Lead Instructor shall submit to the Department at least 60 days, but not more than 90 days, prior to the approval expiration:
   1) A letter of support from an EMS Medical Director indicating that the EMS Lead Instructor has satisfactorily coordinated programs for the EMS System at any time during the four-year period.
   2) Documentation of at least 10 hours of continuing education annually. Programs used to fulfill other professional continuing education requirements, i.e., EMT, nursing, may also be used to meet this requirement.

g) The Department shall, in accordance with Section 515.160 of this Part, *suspend or revoke the approval of an EMS Lead Instructor, after an opportunity for a hearing, when findings show one or more of the following:* the EMS Lead Instructor has failed
   1) *To conduct a course in accordance with the curriculum prescribed by* the Act or this Part; or
   2) *To comply with protocols prescribed by* this Part. (Section 3.65(b)(7) of the Act)

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(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.710 Emergency Medical Dispatcher

a) An individual who acts as an Emergency Medical Dispatcher must be registered with the Department by August 1, 2000.

b) To apply for registration as an Emergency Medical Dispatcher, the individual must submit the following to the Department:
   1) A completed Emergency Medical Dispatcher registration form that includes name, address, System affiliation, and employer of the Emergency Medical Dispatcher; and
   2) Documentation of successful completion of a *dispatching course meeting or exceeding the* National Standard Curriculum for EMS Dispatchers or its equivalent. (Section 3.70(a) of the Act)

c) *Persons who have already completed a course of instruction in emergency medical dispatch based on, equivalent to or exceeding the national curriculum of the United States Department of Transportation, or as otherwise approved by the Department, shall be considered Emergency Medical Dispatchers on* July 19, 1995. (Section 3.70(a) of the Act)

d) An individual acting as an Emergency Medical Dispatcher who does not meet the requirements of subsection (c) of this Section must comply with the following until he or she is registered with the Department:
   1) He or she shall act in accordance with an approved EMS System Program Plan; and
   2) His or her work performance shall be evaluated at one month after employment and at six-month intervals thereafter by the EMSMD or his/her designee.

e) If the Emergency Medical Dispatcher provides both adult and pediatric pre-arrival medical instructions to the caller, *such instructions shall be provided in accordance with protocols established by the EMS Medical Director of the EMS System in which the dispatcher operates. If the dispatcher operates under the authority of an Emergency Telephone System Board established under the Emergency Telephone System Act, the protocols shall be established by the Board in consultation with the EMS Medical Director.* (Section 3.70(a) of the Act)

f) A registered Emergency Medical Dispatcher shall notify the Department within 10 days after any changes in name, address, employee or system affiliation.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.720 First Responder

a) An individual who acts as a First Responder as part of an EMS System's Program Plan must be registered with the Department by August 1, 2000.

b) To register as a First Responder, the individual must submit the following to the Department:

1) A completed First Responder registration form prescribed by the Department, which shall include, but not be limited to, the First Responder's name, address, *EMS System in which he or she participates* as a First Responder, and the employer and supervisor when the individual is acting as a First Responder. (Section 3-650(b)(3) of the Act)

2) Documentation of successful completion of training in accordance with the National Standard Curriculum for First Responders or its equivalent and training in cardiopulmonary resuscitation.

3) Verification that the equipment listed in subsection (d) of this Section will be immediately available to the individual when he or she is acting as a First Responder.

c) *Persons who have already completed a course of instruction in emergency first response based on or equivalent to the national curriculum of the United States Department of Transportation, or who were previously recognized by the Department* as a First Responder on July 19, 1995, *shall be considered First Responders* (Section 3.60(a) of the Act) by submitting to the Department by July 1, 1997, a First Responder registration form and verification that the equipment listed in subsection (d) of this Section will be immediately available to the individual when he or she is acting as a First Responder.

d) As a minimum, when acting as a First Responder an individual shall have the following equipment immediately available:

1) triangular bandage;
2) roller type bandage;
3) universal dressing;
4) gauze pad;
5) occlusive dressing;
6) bandage scissors;
7) adhesive tape;
8) stick (for impaled object/tourniquet);
9) blanket;
10) upper extremity splint;
11) lower extremity splint (set);
12) oxygen equipment and masks (adult and pediatric);
13) bag-mask resuscitator; and
14) oropharyngeal airway (adult, child and infant).

e) A First Responder shall notify the Department, in writing, within 10 days after any changes in:

1) EMS System participation;
2) the First Responder's employer or supervisor; and
3) name or address.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.730 Pre-Hospital Registered Nurse

a) To be approved as a Pre-Hospital RN, an individual shall:

1) Be a registered nurse in accordance with the Illinois Nursing Act of 1987;

2) Complete an education curriculum formulated by an EMS System and approved by the Department, which consists of at least 24 hours of classroom and practical training, including extrication, telecommunications, and pre-hospital cardiac and trauma care of both the adult and pediatric population (Section 3.80(c) of the Act);

3) Complete a minimum of 10 ALS runs supervised by a licensed physician, an approved Pre-Hospital RN or an EMT, only as authorized by the EMS Medical Director; and

4) Complete the Pre-hospital RN application form as prescribed by the Department.

b) The EMS Medical Director shall approve individuals meeting subsection (a) of this Section as a Pre-Hospital RN for four years.

c) The EMS Medical Director shall reapprove Pre-Hospital RNs every four years if the Pre-Hospital RN:

1) Is a registered nurse in accordance with the Illinois Nursing Act of 1987; and

2) Has completed 100 hours of continuing education, the content of which shall be consistent with the System's continuing education requirements for EMT-Ps; and

3) Has a current CPR completion card that covers:

A) Adult one-rescuer CPR,
B) Adult foreign body airway obstruction management,
C) Pediatric one-rescuer CPR,
D) Pediatric foreign body airway obstruction management, and
E) Adult two-rescuer CPR.

d) *All existing Registered Professional Nurse Field RNs* on July 19, 1995, *shall be considered Pre-Hospital Registered Nurses* if they submit a Pre-Hospital RN application form to the EMS Medical Director by July 1, 1997. (Section 3.80(b) of the Act)

e) Inactive Status

1) Prior to the expiration of the current approval, a Pre-Hospital RN may request to be placed on inactive status. The request shall be made in writing to the EMS Medical Director and shall contain the following information:

A) Name of individual;
B) Date of approval;
C) Circumstances requiring inactive status; and
D) A statement that recertification requirements have been met by the date of the application for inactive status.

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2) The EMS Medical Director will review and grant or deny requests for inactive status.

3) For the Pre-Hospital RN to return to active status, the EMS Medical Director must document that the Pre-Hospital RN has been examined physically and mentally) and found capable of functioning within the EMS System, that the Pre-Hospital RN's knowledge and clinical skills are at the active Pre-Hospital RN level, and that the Pre-Hospital RN has completed any refresher training deemed necessary by the EMS system. If the inactive status was based on a temporary disability, the EMSMD shall also verify that the disability has ceased.

4) During inactive status, the individual shall not function as a Pre-Hospital RN.

5) The EMS Medical Director shall notify the Department in writing of Pre-Hospital RN's approval, reapproval, or granting or denying inactive status within 10 days after any change in a Pre-Hospital RN's approval status.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.740 Emergency Communications Registered Nurse

a) To be approved as an ECRN, an individual shall:

1) Be a registered nurse in accordance with the Illinois Nursing Act of 1987;

2) Complete an education curriculum formulated by an EMS System and approved by the Department, which consists of at least 40 hours of classroom and practical training for both the adult and pediatric population, including *telecommunications, system standing medical orders and the procedures and protocols established* by the EMS Medical Director (Section 3.80(c) of the Act);

3) Complete eight hours of field experience supervised by an EMT, only as authorized by the EMS Medical Director; and

4) Complete the ECRN application form as prescribed by the Department.

b) The EMS Medical Director shall approve individuals meeting subsection (a) of this Section as an ECRN for four years.

c) The EMS Medical Director shall reapprove ECRNs every four years if the ECRN:

1) Is a registered nurse in accordance with the Illinois Nursing Act of 1987; and

2) Has completed 32 hours of continuing education in a four-year period.

d) *All existing Registered Professional Nurse/MICWs on July 29, 1995, shall be considered* Emergency Communications Registered Nurses (ECRNs) if they submit an ECRN application form to the EMS Medical Director by

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July 1, 1997. (Section 3.80(a) of the Act)

e) Inactive Status

1) Prior to the expiration of the current approval, the ECRN may request to be placed on inactive status. The request shall be made in writing to the EMS Medical Director and shall contain the following information:

A) Name of individual,

B) Date of approval,

C) Circumstances requiring inactive status,

D) A statement that recertification requirements have been met by the date of the application for inactive status.

2) The EMS Medical Director will review and grant or deny requests for inactive status.

3) For the ECRN to return to active status, the EMS Medical Director must document that the ECRN has been examined (physically and mentally) and found capable of functioning within the EMS System, that the ECRN's knowledge and clinical skills are at the active ECRN level, and that the ECRN has completed any refresher training deemed necessary by the EMS System. If the inactive status was based on a temporary disability, the EMS System shall also verify that the disability has ceased.

4) During inactive status, the individual shall not function as an ECRN at any level.

5) The EMS Medical Director shall notify the Department in writing of the ECRN's approval, reapproval, or granting or denying inactive status within 10 days after any change in an ECRN's approval status.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.750 Trauma Nurse Specialist

a) Trauma Nurse Specialist (TNS) Training Sites

1) Trauma Nurse Specialist courses shall be conducted only at hospitals that have been designated by the Department as TNS Training Sites.

2) The Department shall designate TNS Training Sites based upon regional needs for course availability, the trauma educational and clinical capabilities of interested hospitals, prior Department approval of a hospital as a TNS Training Site, and participation in an EMS System.

3) Any hospital seeking designation as a TNS Training Site must submit an application on a form provided by the Department.

4) The Chief Executive Officer of the hospital designated as a TNS Training Site shall appoint, and endorse in writing to the Department, a Trauma Nurse Specialist Course Coordinator (TNSCC) to plan, coordinate, implement and evaluate the TNS Course and

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TNS Program Activities, who meets the following requirements:

A) Is a registered professional nurse licensed under the Illinois Nursing Act of 1987;

B) Is employed by the TNS Training Site;

C) Has at least three years of experience as a registered professional nurse in an emergency department or critical care setting in a trauma center;

D) Holds a Certificate of TNS Course Completion issued by the Department or its equivalent as provided in this Section; and

E) Has a minimum of 50 hours of teaching experience in emergency critical care nursing courses.

b) The TNSCC shall admit to the TNS Course only those individuals who have met the following requirements:

1) Are currently licensed as a registered nurse in the state in which they are practicing, as verified by the submission of a photocopy of the official document showing the license number and expiration date;

2) Have at least one year of experience as a registered professional nurse; and

3) Have completed a basic electrocardiography (EKG) course. Such a course includes instruction in the recognition of a normal EKG pattern on a monitor as well as the recognition of basic life-threatening dysrhythmias and treatments.

c) The TNS Course shall include at least 90 hours of didactic sessions. The course content shall include but not be limited to the following topics:

1) EMS concepts,

2) Stabilization and transportation of the critically ill or injured,

3) Assessment and management of the traumatized patient,

4) Maxillofacial trauma,

5) Ocular trauma,

6) Neurological anatomy and physiology assessment,

7) Head injury,

8) Spinal injury,

9) Cardiopulmonary trauma,

10) Adjuncts for airway control and ventilation,

11) Acid base-balance and Arterial Blood Gases (ABGs),

12) Abdominal trauma,

13) Genitourinary trauma,

14) Trauma in pregnancy,

15) Musculoskeletal vascular/surface trauma,

16) Thermal injuries,

17) Fluid and electrolytes,

18) Pathogenesis of shock syndrome,

19) Pediatric trauma,

20) Family violence,

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21) Organ procurement,

22) Legal issues,

23) Kinematics,

24) Hypothermia,

25) Trauma in the elderly, and

26) Complications of trauma.

d) The TNS Course shall include eight hours of supervised observational experience from among the following areas:

1) Pre-hospital;

2) Critical care; or

3) Emergency Department.

e) Testing

1) A written pre-test consisting of a minimum of 100 multiple choice questions developed by the Regional Nurse Coordinators and approved by the Department shall be administered on the first day of class. The Regional Nurse Coordinator shall develop the questions based upon the topic outlines and objectives of the curriculum.

2) A practical examination shall be administered at the conclusion of the didactic sessions and clinical experience. The practical examination shall consist of a simulated trauma patient assessment station at which the student will evaluate and stabilize a simulated critically injured patient.

A) The student shall have a maximum of ten minutes to evaluate and stabilize the patient.

B) The student shall be rated on Primary Patient Assessment, Secondary Patient Assessment, Management, Stabilization, and Supervision and Leadership, in accordance with the Trauma Nurse Specialist Course Practical Examination Grading Form developed and provided by the Department along with the TNSCC.

C) A student who receives a failing grade on the practical examination shall be given one opportunity to repeat the practical examination. A failing grade is defined as failure to attain at least 80 percent overall and/or failure to pass all lifesaving techniques asterisked on the Clinical Examination Grading Form.

D) The TNSCC may designate other individuals to assess student performance in the Practical Examination when the class size exceeds eight students. Such individuals shall meet the same qualifications as described in subsection (a)(4) of this Section with the exception of subsections(a)(4)(B) and (F).

3) A student who has successfully completed the didactic sessions and clinical experience shall be eligible to take the final written examination. This final examination shall consist of 150 multiple choice questions developed by the Regional Nurse Coordinator using the objectives and topics of the TNS curriculum

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and approved by the Department. A score of 80 percent or above shall be a passing grade.

A) A student shall be given an opportunity to retake the final written examination within ten days after the original examination date.

B) The TNSCC shall extend the ten day retake period on an individual basis for reasons of a death in the student's family, or illness or injury to the student or student's family.

i) Each TNS site shall offer a minimum of two practical and final written examinations per year. Additional examinations shall be offered based upon regional needs.

j) Any individual who has met the admission requirements provided in subsection (b) of this Section has the option of taking the TNS Practical Examination and final written examination without having completed the didactic sessions or clinical experience. The individual must file a request for this testing option with the TNS Training Site at least 30 days prior to the scheduled practical examinations.

f) Certification as a TNS

1) A student may apply to the Department for certification by submitting:

A) Documentation provided by the TNSCC of receiving a passing score on the final written examination and the practical examination;

B) A fee of $25.00 in the form of a certified check or money order made payable to the Department (personal checks or cash will not be accepted); and

C) A completed TNS Certification Application form.

2) Certification is effective for four years.

3) A TNS may apply for recertification by submitting the following at least 60 days but no more than 90 days prior to certification expiration:

A) TNS Certification/Recertification Application;

B) Verification of successful completion of the examination; or

C) Documentation of any 60 hours of continuing education every two years, to include at least the following:

i) Trauma nursing seminars;

ii) Emergency perioperative critical care nursing seminars relating to trauma management;

iii) Teaching of trauma or emergency nursing classes;

iv) Basic Trauma Life Support (BTLS), Pre-hospital Trauma Life Support (PHTLS), Pediatric Advanced Life Support (PALS) or Trauma Nurse Core Curriculum (TNCC);

v) Other topics/offerings approved by the Department and the TNSCC;

D) The recertification candidate is responsible for his/her record keeping and submission of continuing education documentation.

g) A Department-issued certificate of completion for a Department-sponsored trauma nurse specialist course completed prior to the adoption of this Part shall be recognized as equivalent to the Certificate of TNS Course Completion issued pursuant to this Part.

h) Inactive Status

1) Prior to the expiration of the current certification, a TNS may request to be placed on inactive status. The request shall be in writing, in a form prescribed by the Department, and shall contain the following information:

A) Name of individual;

B) Date of certification;

C) Circumstances requiring inactive status; and

D) A statement that recertification requirements have been met by the date of the application for inactive status.

2) The Department will review requests for inactive status. The Department shall notify the individual TNS in writing of its decision based on subsection (h)(1) of this Section.

3) For the TNS to return to active status, the application must be in writing and include a statement that the TNS's knowledge and clinical skills are at the active TNS level, and that the TNS has completed any "refresher training deemed necessary" by the respective TNSCC.

4) During inactive status, the individual shall not function as a TNS.

i) A TNS whose certification has expired may, within 60 days after certification expiration, submit all recertification material as required in this Section and a fee of $25.00 in the form of a certified check or money order (cash or personal check will not be accepted). If all material is in order and there is no disciplinary action pending against the TNS, the Department will recertify the TNS.

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.800 Vehicle Service Provider Licensure

a) An application for a Vehicle Service Provider license shall be submitted on a form prescribed by the Department. The application shall include, but not be limited to, licensee name, address and telephone number; and, for each vehicle to be covered by the license, make, model, year, identification number, state vehicle license number and level of service (BLS, ILS or ALS).

b) The application shall be accompanied by a fee of $25 for each vehicle included in the license application up to 20 vehicles. A fee of $500.00 shall be submitted for applications with 20 or more vehicles.

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c) An application for license renewal shall be submitted to the Department in accordance with subsections (a) and (b) of this Section at least 60 days but no more than 90 days prior to license expiration.

d) The Department shall issue a license valid for one year if, after inspection, the Department finds that the vehicle service provider is in compliance with the Act and this Part.

e) The Department shall have the right to make inspections and investigations as necessary to determine compliance with the Act and this Part. Pursuant to any inspection or investigation, a licensee shall allow the Department access to all records, equipment and vehicles relating to activities addressed by the Act and this Part.

f) Each license is issued to the licensee for the vehicles identified in the application. The licensee shall notify the Department, in writing, within ten days after any changes in the information on the application. Additional vehicles shall not be put in service until an application is submitted with the proper fee and an inspection is conducted. To change a vehicle's level of service, notification must be made in accordance with subsection (g) of this Section.

g) Each vehicle covered by an ambulance service provider license shall be approved by the Department to operate at a specific level of service (BLS, ILS or ALS). To change the level of service for a specific vehicle:

1) The licensee shall submit a written request to the EMS Medical Director.

2) The EMS Medical Director shall submit a copy of that request to the Department, along with written verification that the licensee meets the equipment and staffing requirements of this Part and the EMS System Plan for the requested level of services.

3) The Department shall then amend the provider license and vehicle certificate to reflect the new level of service.

h) *All Vehicle Service Providers* shall *function within an EMS System.* (Section 3.35(b) of the Act)

i) *A Vehicle Service Provider utilizing ambulances* shall *have a primary affiliation with an EMS System within the EMS Region in which its Primary Service Area is located.* This does not *apply to Vehicle Service Providers which exclusively utilize Limited Operation Vehicles.* Section 3.35(b) of the Act)

j) *A Vehicle Service Provider* is prohibited *from advertising, identifying its vehicles, or disseminating information in a false or misleading manner concerning the Provider's type and level of vehicles, location, primary service area, response times, level of personnel, licensure status or System participation.* (Section 3.35(b) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.810 EMS Vehicle System Participation

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For each EMS vehicle participating within the System, the following documentation shall be provided:

a) A list of the following:

1) The year, model, make, and vehicle identification number;

2) The license plate number;

3) The Department license number;

4) The base location address; and

5) The level of service (advanced, intermediate or basic);

b) A description of the vehicle's role in providing advanced life support, intermediate life support, basic life support and patient transport services within the System;

c) Definitions of the primary, secondary and outlying areas of response for each EMS vehicle used within the System;

d) A map or maps indicating the base locations of each EMS vehicle, the primary, secondary and outlying areas of response for each EMS vehicle, the population base of each service area and the square mileage of each service area;

e) A commitment to optimum response times up to six minutes in primary coverage areas, six to 15 minutes in secondary coverage areas, and 15 to 20 minutes in outlying coverage areas;

f) A commitment to 24-hour coverage;

g) A commitment that within one year after Department approval of a new or upgraded vehicle service, each ambulance at the scene of an emergency and during transport of emergency patients to and between hospitals will be staffed in accordance with the requirements of Section 515.830(f)(1) and (2) of this Part;

h) Copies of written mutual aid agreements with other providers and/or a description of the provider's own back-up system, which detail how adequate coverage will be ensured when an EMS vehicle is responding to a call and a simultaneous call is received for service within that vehicle's coverage area;

i) A statement that emergency services that an EMS vehicle is authorized to provide shall not be denied on the basis of the patient's inability to pay for such services;

j) An agreement to use an appropriate EMS run sheet or form for each emergency call, as required by the System;

k) An agreement to maintain the equipment required by Section 515.830 of this Part and by the System, in working order at all times, and to carry the medication as required by the System;

l) An agreement to notify the EMS Medical Director of any changes in personnel providing pre-hospital care in the System in accordance with the policies in the System Manual;

m) A copy of its current DOC license(s);

n) A description of the mechanism and specific procedures used to access and dispatch the EMS vehicles within their respective service areas;

o) A list of all personnel providing pre-hospital care, their license numbers, expiration dates and levels of licensure (EMT-B, EMT-I, EMT-P), and their Pre-Hospital RN or MD status;

p) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;

q) An agreement to allow the EMS Medical Director or designee access to all records, equipment and vehicles relating to the System during any inspection or investigation by the EMSMD or designee to determine compliance with the System Program Plan;

r) Documentation that its communications capabilities meet the requirements of Section 515.410 of this Part;

s) Documentation that each EMS vehicle participating in the System complies with the vehicle design, equipment and extrication criteria as provided in Section 515.833(a)(1) and (b) of this Part; and

t) An agreement to follow the approved EMS policies and protocols of the System.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.820 Denial, Nonrenewal, Suspension and Revocation of a Vehicle Service Provider License

a) The Director shall, in accordance with Section 515.60 of this Part and after providing notice and an opportunity for an administrative hearing to the applicant or licensee, deny, suspend, revoke or refuse to renew a vehicle service provider license in any case in which it is found that the applicant, licensee or vehicles fail to comply with the requirements of the Act or this Part.

b) If the failure to comply relates only to one or more specific vehicles operated by the applicant or licensee, and the applicant or licensee has one or more vehicles that are in compliance, the Director's action shall be limited to those vehicles which fail to comply with the Act or this Part.

c) If the failure to comply concerns all of the provider's vehicles or the provider's operation as a whole, the Director's action shall cover the entire vehicle service provider license.

d) In the event that an *immediate* and *serious danger* to the public health, safety or welfare exists, the Director shall issue an *emergency suspension order for any* Provider or vehicle licensed under the Act and this Part. Section 3-55(c) of the Act. Subsequent to the emergency suspension order, the Director shall promptly institute proceedings to revoke or suspend the license or portion thereof and provide the Licensee with an opportunity for an administrative hearing. The emergency suspension shall remain in effect throughout the course of such proceedings, unless the Director lifts the suspension order after determining that the emergency situation has been corrected or remedied. In determining whether to lift the suspension, the Director will consider whether or not patient care is compromised.

e) All administrative hearings conducted pursuant to this Section shall be governed by the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100).

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.830 Ambulance Licensing Requirements

a) Vehicle Design

1) Each new vehicle used as an ambulance after the effective date of this Part shall comply with the criteria established by the U.S. General Services Administration's Specification for Ambulance KKK-A-1822D).

2) *A Licensed Vehicle shall be exempt from subsequent vehicle design standards or specifications required by the Department in this Part, as long as said vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until said vehicle's title of ownership is transferred.* Section 3.35(b)(3) of the Act)

3) The following requirements listed in Specification KKK-A-1822D shall be considered mandatory in Illinois even though they are listed as optional in that publication:

A) 3.7.1.1 Each vehicle will be equipped with either a battery charger or battery conditioner (see 3.15.3 item F).

B) 3.8.3.2 Patient Compartment overhead lights will be provided (see 3.15.3 item B).

C) 3.12.1 An oxygen outlet will be provided above the secondary patient (see 3.15.4 M9).

D) 3.15.4M3 Electric clock with sweep second hand will be provided.

4) An "End Seat" device may be placed at the forward edge of the squad bench to prevent the secondary patient from forward motion due to severe braking or in a frontal impact accident when a long backboard is used. This device can be fixed or removable.

b) Equipment Requirements - Basic Life Support Vehicles

Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:

1) Stretchers, Cots, and Litters

A) Primary Patient Cot
Must meet the requirements of sections 3.11.5, 3.11.8.1 of KKK-A-1822D.

B) Secondary Patient Stretcher
Must meet the requirements of sections 3.11.5, 3.11.5.1, 3.11.8.1 of KKK-A-1822D.

2) Oxygen, portable

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Must meet the operational requirements of section 3.12.2 of KKK-A-1822-D.

3) Suction, portable
   A) Must meet the operational requirements of section 3.12.4 of KKK-A-1822D.
   B) A manually operated suction device is acceptable if approved by the Department.
4) Medical Equipment
   A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask and child size bag-valve-mask ventilation unit with child and infant size transparent masks
   B) Lower-extremity traction splint, adult and pediatric sizes
   C) Blood pressure cuff, one each, adult, child and infant sizes and gauge
   D) Stethoscopes, two each
   E) Pneumatic counterpressure trouser kit, adult size, optional
   F) Long spine board with three sets of torso straps, 72" x 16" minimum
   G) Pediatric long spine board with two sets of torso straps
   H) Short spine board (32" x 16" minimum) with two 3-foot torso straps, one each chin and head strap or equivalent vest type (wrap around) extrication device optional
   I) Airway, oropharyngeal - adult, child, and infant sizes
   J) Airway, nasopharyngeal with lubrication, sizes 12-30F
   K) Bandage sheets, one each
   L) Extremity splints, adult, two each long and short
   M) Extremity splint, pediatric, two each long and short
   N) Rigid cervical collars - one each, pediatric, small, medium, and large sizes. Shall be made of rigid material to minimize flexation, extension, and lateral rotation of the head and cervical spine when spine injury is suspected
   O) Patient restraints, arm and leg, sets
5) Medical Supplies
   A) Trauma dressing - six each
   B) Sterile gauze pads - 10 each, four inches by four inches
   C) Bandages, soft roller, self-adhering type, ten each, four inches by five yards
   D) Gauze pads - two each, three inches by eight inches
   E) Adhesive tape rolls - two each
   F) Triangular bandages or slings - five each
   G) Burn sheets - two each, clean, individually wrapped
   H) Sterile solution (normal saline) - four each, 500 cc or two each, 1,000 cc plastic bottles or bags
   I) Aluminum foil roll or Silver Swaddler - one each with head cover
   J) Obstetrical kit, sterile - one each, pre-packaged with instruments
   K) Cold packs, three each

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   L) Hot packs, three each, optional
   M) Emesis basin - one each
   N) Drinking water - one quart, in nonbreakable container; sterile water may be substituted
   O) Ambulance emergency run reports - ten each, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form as described in Section 515.Appendix E of this Part
   P) Pillows - two each, for ambulance cot
   Q) Pillowcases - two each, for ambulance cot
   R) Sheets - two each, for ambulance cot
   S) Blankets - two each, for ambulance cot
   T) CPR mask - one each, with safety valve to prevent backflow of expired air and secretions
   U) Urinal
   V) Bedpan
   W) Remains bag, optional
   X) Nonporous disposable gloves
   Y) Impermeable red Biohazard-labeled isolation bag
   Z) Face protection (through any combination of masks and/or eye protection and/or field shields)
   AA) Suction (catheters - sterile, single use, two each, six, eight, ten, 12, 14 and 18F, plus three each tonsil tip semi-rigid pharyngeal suction tip catheters; all must have a thumb suction control port)
   BB) Child/infant car seat
   CC) Equipment drug dosage sizing tape or pediatric equipment drug age/weight chart
   DD) Pediatric Trauma Score Reference
   EE) Poison Control Resource Phone Number
   FF) Plastic baby bottle with nipple for glucose feeding
   GG) Flashlight, one each, for patient assessment

c) Equipment Requirements - Intermediate and Advanced Life Support Vehicles

Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and d) of this Section and shall also comply with the equipment and supply requirements as determined by the EMS Medical Director or the System in which the ambulance and its crew participate. Drugs shall include adult and pediatric dosages.

d) Equipment Requirements - Rescue and/or Extrication

The following equipment will be carried on the ambulance, unless it is routinely accompanied by a rescue vehicle:
   1) Wrecking bar, 24"
   2) Goggles for eye safety
   3) Flashlight - one each, portable, battery operated

e) Equipment Requirements - Communications Capability

Each ambulance must have ambulance-to-hospital radio communications

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capability and meet the requirements provided in Section 515.400 of this Part.

f) Personnel Requirements

1) Each ambulance shall be staffed by a minimum of two EMTs, Pre-Hospital RNs or physicians on all emergency calls.

2) Each Basic Life Support vehicle using automated defibrillation shall be staffed by a minimum of one EMT-B approved by the EMS Medical Director for automated defibrillation, a Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician.

3) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one EMT-I, Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician. Each ILS vehicle using automated defibrillation shall be staffed by a minimum of one EMT-I approved by the EMS Medical Director for automated defibrillation, a Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician. Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one EMT-P, Pre-Hospital RN or physician and one other EMT, Pre-Hospital RN or physician.

4) Each ambulance provider that operates an emergency transport vehicle shall ensure through written agreement with the EMS System that the emergency providing emergency care at the scene and enroute to a hospital meets the requirements of this Subpart.

g) Operational Requirements

1) Any operation of an ambulance while transporting a patient to a hospital shall be done in accordance with the requirements of the Act and this Part.

2) A licensee shall operate its ambulance service in compliance with this Part, 24 hours a day, every day of the year. Except as required below, each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least the vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS or BLS level, and such coverage will meet the requirements of this Section.

A) At the time of application for initial or renewal licensure, the applicant or licensee shall submit to the Department for approval a list terminating the anticipated hours of operation for each vehicle covered by the license.

i) A current roster shall also be submitted, which lists the EMTs, Pre-Hospital RNs and or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, and daytime telephone number, and shall state whether such person is generally scheduled to be on site or on call.

ii) An actual or proposed four-week staffing schedule shall also be submitted, which covers all vehicles,

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includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

B) Licensees shall be required to obtain the EMS Medical Director's approval of their vehicles' hours of operation prior to submission to the Department. An EMS Medical Director may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.

C) A licensee that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in such advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day.

3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Section 515.Appendix E.

4) A licensee shall provide emergency service within the service area on a non-need basis without regard to the patient's ability to pay for such service.

5) A licensee shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.321(h) of this Part.)

6) A licensee shall operate its ambulance at a level not exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless such vehicle is operated pursuant to an EMS System-approved in-field service level upgrade.

h) A licensee may use a replacement vehicle for up to ten days without a Department inspection provided that the Department is notified of the use of the vehicle by the second working day.

AGENCY NOTE: Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.140.

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART J: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section 515.900 Licensure of SEMSV Programs - General

a) No person, either as owner, agent or otherwise shall furnish, operate, conduct, maintain, advertise or otherwise be engaged in the provision of emergency medical care or transportation to a sick or injured patient using a Specialized Emergency Medical Services Vehicle

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(SEMSV), unless currently licensed by the Department pursuant to this Subpart. This requirement applies to:

1) Any air medical service that may pick up or deliver a patient within the State of Illinois; and

2) Any provider that advertises that it provides air medical transport services, regardless of its base of operation, location of vehicle registration, or percentage of vehicle use for air medical transport.

b) An application for licensure shall be filed with the Department by submitting a Program Plan that includes the information required in this Part. The Program Plan shall be signed by the SEMSV Medical Director and the EMS Medical Director of the EMS System of which the SEMSV Program is a part. See Section 515.920(a) of this Part.)

c) Each licensure shall be valid for a period of one year from the date of issuance, unless suspended or revoked.

d) Each license shall be issued to the program named in the application for the specific vehicle(s) identified in the application and shall not be assignable or transferable.

e) An application for renewal of licensure shall be filed with the Department at least 30 days prior to the expiration date on a form prescribed by the Department. The renewal application shall be accompanied by photocopies of any current licenses or certificates required of SEMSV personnel by the provisions of this Part see Sections 515.910 e), 515.935, 515.940(a) of this Part) and verification that SEMSV personnel continuing education required by the provisions of this Part have been met. See Section 515.930(d) of this Part.) Each renewed license shall be valid for a period of one year from the date of issuance, unless suspended or revoked.

f) The Department shall inspect any vehicles, equipment, records or other documents covered by the licensed or applicant SEMSV Program annually to determine initial or continued compliance with the requirements of the Act or this Part.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.910 Denial, Nonrenewal, Suspension or Revocation of SEMSV Licensure

a) The Director may issue an Emergency Suspension Order for any Provider or Vehicle licensed under this Part if he or she, when the Director or his designee has determined that an immediate and serious danger to the public health, safety and welfare exists. Suspension or revocation proceedings which offer an opportunity for hearing shall be promptly initiated after the emergency suspension order has been issued. Section 7.05 b)(7) of the Act)

b) The Department, in accordance with Section 515.160 of this Part, after

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notice and an opportunity for hearing, shall deny an application for licensure or renewal, suspend or revoke a license when the applicant or license holder has failed to meet or has violated any of the requirements of the Act or this Part, or any SEMSV personnel, during the provision of emergency services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public, such as not meeting the requirements of the Act, charging for services or equipment not provided or used, or using unqualified personnel as provided in Section 515.940.

c) All hearings shall be governed by the Department's Rules of Practice and Procedures in Administrative Hearings (77 Ill. Adm. Code 100). Upon receipt of a notice to deny, nonrenew, suspend or revoke, the applicant or certificate holder shall have 15 days in which to request such a hearing.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.920 SEMSV Program Licensure Requirements for All Vehicles

a) The SEMSV Program shall be part of a Department-approved EMS System.

b) The SEMSV Program shall meet and comply with all State and federal requirements governing the specific vehicles employed in the program. See Sections 515.930, or 515.935, or 515.970 of this Part.)

c) The SEMSV Program shall comply with this Part during its hours of operation. The SEMSV Program shall operate 24 hours per day, every day of the year, in accordance with weather conditions, except when the service is committed to another medical emergency request, or is unavailable due to maintenance requirements.

d) The SEMSV Program shall provide pre-hospital emergency services within its service area on a per-need basis without regard to the patient's ability to pay for such service.

e) The SEMSV Program shall be supervised and managed by a Medical Director, who shall be a physician who has met at least the following requirements:

1) Educational experience in those areas of medicine that are commensurate with the mission statement of the air medical service e.g., trauma, pediatric, neonatal, obstetrical, or airline specialty physicians as consultants when appropriate;

2) Training and experience in Advanced Cardiac Life Support (ACLS), such as the American Heart Association's ACLS course or equivalent education;

3) Training and experience in Pediatric Advanced Life Support (PALS), such as the American Heart Association PALS course or ASEP American Academy of Pediatrics Advanced Pediatric Life Support course or equivalent education;

4) Training and experience in Advanced Trauma Life Support (ATLS), such as the American College of Surgeons ATLS course;

5) In programs using air vehicles, documentation, such as certificates of completion in course work designed to bring about
   A) Experience and knowledge in inflight treatment modalities;
   B) Experience and knowledge in altitude physiology;
   C) Experience and knowledge in infection control as it relates to airborne and intra-facility transportation; and
   D) Experience and knowledge in stress management techniques;
6) In programs using watercraft, documentation, such as certificates of completion in course work designed to bring about
   A) Experience and knowledge in treating persons suffering from drowning (cold, warm, fresh and salt water); and
   B) Experience and knowledge in diving accident physiology and treatment.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.930 Helicopter and Fixed-Wing Aircraft Requirements

In addition to the requirements specified in Sections 515.900 and 515.920 of this Part, an SEMSV Program using helicopters or fixed-wing aircraft shall submit a Program Plan that includes the following:

a) Documentation of the Medical Director's credentials as required by Section 515.920(e) of this Part, and a statement signed by the Medical Director containing his or her commitment to the following duties and responsibilities:
   1) Supervising and managing the program;
   2) Supervising and evaluating the quality of patient care provided by the aeromedical crew;
   3) Developing written treatment protocols and standard operating procedures to be used by the aeromedical crew during flight;
   4) Developing and approving a list of equipment and drugs to be available on the SEMSV during patient transfer;
   5) Providing periodic review, at least monthly, of patient care provided by the aeromedical crew;
   6) Providing for the continuing education of the aeromedical team;
   7) Providing medical advice and expertise on the use, need and special requirements of aeromedical transfer;
   8) Submitting documentation assuring the qualifications of the aeromedical crew;
   9) Notifying the Department when the primary SEMSV is unavailable in excess of 24 hours, stating the reason for unavailability, the expected date of return to service, and the provisions made, if any, for replacement vehicles;
   10) Assuring appropriate staffing of the SEMSV, with a minimum of one EMS pilot and one aeromedical crew member for Basic Life Support missions. There shall be two aeromedical crew members for Advanced Life Support and Critical Care transports. Two EMS pilots shall be used for fixed-wing aircraft or helicopters requiring such staffing. Additional aeromedical personnel may be required at the discretion of the SEMSV Medical Director. The Medical Director shall provide the Department with a list of all approved pilots and aeromedical crew members, and shall update the list whenever a change in such personnel is made.

b) The SEMSV Medical Director's list of required medical equipment and drugs for use on the aircraft (see Section 515.950);
c) The SEMSV Medical Director's treatment protocols and standard operating procedures;
d) The curriculum and requirements for orientation and training, including mandatory continuing education for all aeromedical crew members consisting of at least 16 hours in specialized aeromedical transportation topics, eight hours of which may include quality assurance reviews;
e) A description of the communications system accessing the aeromedical dispatch center, the medical control point, receiving and referring agencies (see Section 515.960 of this Part);
f) A description and map of the service area for each vehicle;
g) A description of the EMS System's method of providing emergency medical services using the SEMSV Program; and
h) The identification number and description of all vehicles used in the program.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.935 EMS Pilot Specifications

a) EMS Pilot approval for helicopters and fixed-wing aircraft shall be valid for a period of one year and may be renewed by the Medical Director if the pilot has completed renewal training, which shall include but is not limited to the requirements of subsections (b)(1) and (5)(A) through (H) or subsections (c)(1) and (3)(A) through (F) of this Section.
   1) For helicopter programs only:
      A) Four EMS pilots per helicopter, excluding relief support, shall be dedicated to the SEMSV Program.
      B) An EMS pilot assigned to SEMSV duty shall be physically present at the aircraft base to assure timely response.
      C) An EMS pilot assigned to SEMSV duty shall be provided with work space to carry out assigned duties. In the event that duty time exceeds 12 continuous hours, separate sleeping quarters shall be provided to assure physical rest.
   2) For fixed-wing programs only: One EMS pilot per aircraft who will respond within one-half hour from the receipt of the request.
b) Each EMS Pilot assigned to a helicopter shall be approved by the

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Medical Director and shall meet the following requirements:

1) Compliance with subparts E and F of Air Taxi Operations and Commercial Operators (14 CFR 135).

2) A minimum of 2000 rotorcraft flight hours as pilot-in-command, including:

A) Factory school or equivalent (ground and flight);

B) Five hours as pilot-in-command or at the controls prior to EMS missions if transitioning from a single to a single engine helicopter, from a twin to a single engine helicopter, or from a twin to a twin engine helicopter;

C) Ten hours as pilot-in-command or at the controls prior to EMS missions if transitioning from a single to a twin engine aircraft.

3) A minimum of five hours day/night area flight orientation and, in the judgement of the SEMSV Medical Director, special terrain flight orientation.

4) Instrument Flight Rules (IFR) certification by the Federal Aviation Administration (IFR Currency is recommended).

5) Provide documentation of completion of training that includes but is not limited to the following:

A) Judgement and decision making;

B) Local routine operating procedures, including day and night operations;

C) Flight by reference to instruments, including Instrument Meteorological Conditions (IMC) recovery;

D) Regional area weather phenomena;

E) Area terrain hazards;

F) Scene procedures;

G) EMS System and SEMSV Program communications requirements; and

H) Orientation to each hospital/pre-hospital health care system affiliated with the SEMSV Program.

c) Each pilot assigned to a fixed-wing aircraft shall be approved by the Medical Director and shall meet the following requirements:

1) Compliance with supparts E and F of Air Taxi Operations and Commercial Operators (14 CFR 135);

2) The pilot shall have a commercial pilot certificate with a minimum of 2000 flight hours as pilot-in-command and an airplane multi-engine land instrument rating, with a minimum of 250 hours of instrument flying time, to include no more than 125 hours of simulated time and 100 night flight hours;

3) Provide documentation of completion of training that includes but is not limited to the following:

A) Judgement and decision making;

B) Local routine operating procedures, including day and night operations;

C) Flight by reference to instruments, including Instrument Meteorological Conditions (IMC) recovery;

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D) Regional area weather phenomena;

E) Area terrain hazards; and

F) EMS System and SEMSV Program communications requirements.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.940 Aeromedical Crew Member Training Requirements

a) Except as provided for by subsection (b) of this Section, each aeromedical crew member assigned to a helicopter or fixed-wing aircraft shall be approved by the Medical Director and shall meet the following requirements:

1) Be an EMT-P, registered nurse or a physician.

2) Provide documentation of completion of didactic training that includes but is not limited to the following:

A) Advanced life support,

B) Cardiac emergencies,

C) Traumatic emergencies,

D) Pediatric emergencies,

E) Obstetrical emergencies,

F) Neonatal emergencies,

G) Psychiatric emergencies,

H) Crisis intervention,

I) Infection control,

J) Altitude physiology,

K) Advanced surgical and airway management techniques,

L) Environmental emergencies,

M) Flight safety,

N) Aircraft emergencies,

O) Radio communications,

P) Rescue and survival techniques,

Q) Record keeping, and

R) Legal aspects.

3) Provide documentation of completion of clinical training appropriate for the scope of care of the air medical service that includes but is not limited to the following:

A) Emergency/trauma care,

B) Critical/intensive care (adult, pediatric, neonatal),

C) Obstetrics,

D) Invasive procedure labs, including tracheal intubations, and

E) Pre-nospital care.

4) Yearly completion of the continuing education requirements as described in Section 515.930 (d) of this Part.

b) In addition to at least one aeromedical crew member who has met the requirements of subsection (a) of this section, the Medical Director may approve and assign additional crew members to a helicopter or fixed-wing aircraft. Such additional crew members shall meet the

following requirements:

1) Provide documentation of completion of training that includes but is not limited to the following:
   A) General patient care in-flight,
   B) Aircraft emergencies,
   C) Flight safety,
   D) EMS System and SEMSV Program communications,
   E) Use of all patient care equipment, and
   F) Rescue and survival techniques.
2) Yearly completion of the continuing education requirements as described in Section 515.930 (d) of this Part.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.945 Aircraft Vehicle Specifications and Operation

a) All vehicles shall meet the requirements of subparts A, B, C, and D of Air Taxi Operations and Commercial Operators (14 CFR 135).
b) All vehicles shall have communication equipment to permit both internal crew and air-to-ground exchange of information between individuals and agencies, including at least those involved in SEMSV medical control within the EMS System, the flight operations center, air traffic control and law enforcement agencies.
c) All vehicles shall be designed to allow the loading and unloading of the patient without rotating the patient more than 30 degrees along the longitudinal axis or 45 degrees along the lateral axis.
d) All vehicles shall be climate controlled to prevent temperature extremes that would adversely affect patient care in the judgement of the Medical Director.
e) All vehicles shall have interior lighting to permit patient care to be given and patient status to be monitored without interfering with the pilot's vision.
f) All vehicles shall carry survival equipment including but not limited to:
   1) Two sources of heat or fire,
   2) Two forms of signaling device,
   3) Equipment to provide shelter: blanket, nylon cord and adhesive tape,
   4) Knife and fishing kit, and
   5) Food and water supply.
g) All patients shall be restrained to the helicopter or fixed-wing aircraft litter in order to assure the safety of the patient and crew.
h) For helicopter programs:
   1) There shall be at least one single-engine aircraft.
   2) Each vehicle shall be staffed with at least one EMS pilot and at least one aeromedical crew member for Basic Life Support missions. There shall be two aeromedical crew members for

Advanced Life Support and critical care transports.
   3) Each vehicle shall be equipped with flight reference instruments to allow recovery from inadvertent Instrumental Flight Rules (IFR) situations.
   4) Each vehicle shall be equipped with a searchlight pivoting at least 180 degrees horizontal and 90 degrees vertical, controlled by the pilot without removing hands from the flight controls.
   5) The cockpit shall be isolated by a protective barrier to minimize inflight distraction or interference.
   6) All medical equipment, supplies and personnel shall be secured and/or restrained.
i) For fixed-wing aircraft programs:
   1) There shall be at least one twin-engine aircraft.
   2) Each vehicle shall be staffed with at least one EMS pilot and at least one aeromedical crew member for Basic Life Support missions. There shall be two aeromedical crew members for Advanced Life Support and critical care transports.
   3) The aircraft shall be IFR equipped and certified.
   4) All equipment, litters/stretchers and seating shall be arranged so as not to block rapid egress by personnel or patient from the aircraft and shall be affixed or secured in approved racks or compartments or by strap restraint.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.950 Aircraft Medical Equipment and Drugs

a) Each helicopter or fixed-wing aircraft shall be equipped with medical equipment and drugs that are appropriate for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.
b) The SEMSV Medical Director shall submit for approval to the Department a list of medical equipment and drugs to be taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.955 Vehicle Maintenance for Helicopter and Fixed-wing Aircraft Programs

a) For helicopter programs:
   1) The maintenance program shall meet the requirements of subpart J of Air Taxi Operations and Commercial Operators (14 CFR 135).
   2) One certified airframe and power plant (A & P) mechanic with two

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years experience for each helicopter shall be available and dedicated to the program 24 hours per day.

3) Mechanics shall have completed factory-provided training for the makes and models of aircraft used in the SEMSV Program.

4) Back-up maintenance support shall be available when the primary mechanic is unavailable or during times of extensive maintenance needs.

5) Hangar facilities shall be available for major maintenance activities, as specified in manufacturer's requirements. These facilities need not be located at the base of operations.

6) Progressive maintenance on aircraft used by the SEMSV Program is recommended, including routine daily inspections, as required by the aircraft manufacturer.

b) For fixed-wing aircraft programs:

1) The maintenance program shall meet the requirements of subpart J of Air Taxi Operations and Commercial Operators (14 CFR 135).

2) Mechanics shall be certified A & P with two years experience, and shall have completed training for the make and model of aircraft used by the SEMSV Program.

3) Hangar facilities shall be available for major maintenance activities as specified in manufacturer's requirements.

4) Progressive maintenance on aircraft used by the SEMSV Program is recommended, including routine daily inspections, as required by the aircraft manufacturer.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.960 Aircraft Communications and Dispatch Center

a) The SEMSV Program shall have a designated person assigned and available 24 hours per day every day of the year to receive and dispatch all requests for aeromedical services. For fixed-wing aircraft programs, a telephone answering service may be used.

b) The dispatch center shall have at least one dedicated telephone number for the SEMSV Program.

c) A pre-arranged emergency plan shall be in place to cover situations in which an aircraft is overdue, radio communication cannot be established, or an aircraft location cannot be verified.

d) A back-up power source shall be available for all communications equipment used at the SEMSV medical control point.

e) In addition, for helicopter programs:

1) The dispatch center shall have the capability to communicate with the aircraft pilot and aeromedical crew for nonmedical purposes on a separate designated frequency.

2) Continuous flight following every 15 minutes shall be maintained and documented.

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(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.965 Watercraft Requirements

In addition to the requirements specified in Sections 515.900 and 515.920 of this Part, an SEMSV Program using watercraft shall submit a program plan that includes the following:

a) Documentation of the Medical Director's credentials as required by Section 515.920(e) of this Part, and a statement signed by the Medical Director containing his or her commitment to the following duties and responsibilities:

1) Supervising and managing of the program;

2) Supervising and evaluating the quality of patient care provided by the watercraft crew;

3) Developing written treatment protocols and standard operating procedures to be used by the watercraft crew during vehicle operation;

4) Developing and approving a list of equipment and drugs to be available on the SEMSV during patient transfer;

5) Providing periodic review, at least quarterly, of patient care provided by the watercraft crew;

6) Providing medical advice/expertise on the use, need and special requirements of watercraft transfer;

7) Submitting documentation assuring the qualifications of the watercraft crew;

8) Assuring appropriate staffing of the SEMSV:

A) Each watercraft crew member assigned to a watercraft shall be approved by the Medical Director, who shall provide the Department with a list of all approved crew members and watercraft operators and update the list whenever a change in such personnel is made.

B) For Advanced Life Support (ALS) operations, the watercraft shall be staffed by a crew of at least one EMT-P, registered nurse or physician, and one other EMT, registered nurse or physician, in addition to the watercraft operator.

C) For Basic Life Support (BLS) operations, the watercraft shall be staffed by a crew of at least two EMTs, registered nurses or physicians, one of whom may also be the watercraft operator.

D) Except as provided for by subsection (a)(8)(E) of this Section, each watercraft crew member shall document the completion of training that includes but is not limited to the following:

i) Advanced life support,

ii) Cardiac support,

iii) Traumatic emergencies,

iv) Pediatric emergencies,

v) Psychiatric emergencies,
vi) Crisis intervention,
vii) Infection control,
viii) Advanced surgical and airway management techniques,
ix) Environmental emergencies,
x) Radio communications,
xi) Rescue and survival techniques,
xii) Record keeping,
xiii) Legal aspects,
xiv) Certification in Advanced Life Saving by the American Red Cross, and
xv) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act (625 ILCS 45).

E) In addition to at least two watercraft crew members who have met the requirements of subsections (a)(8)(B) through (D) of this Section, the Medical Director may approve and assign additional watercraft crew members to a watercraft. Such additional watercraft crew members shall document the completion of training that includes but is not limited to the following:
i) General patient care,
ii) Watercraft emergencies,
iii) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act,
iv) EMS System and SEMSV Program communications,
v) Use of all patient care equipment,
vi) Rescue and survival techniques, and
vii) Certification in Advanced Life Saving by the American Red Cross.

F) Watercraft operators shall be at least 21 years of age and shall meet the following requirements:
i) Certification in Advanced Life Saving by the American Red Cross, and
ii) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act.

b) The SEMSV Medical Director's list of required medical equipment and drugs for use on the watercraft (see Section 515.275);
c) The SEMSV Medical Director's standing orders (treatment protocols, standard operating procedures);
d) A description of the communications system linking the watercraft with the SEMSV medical control point;
e) A description of the EMS System's method of providing emergency medical services using the SEMSV Program;
f) A description and map of the service area for each vehicle; and
g) The identification number and description of all vehicles used in the program.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.970 Watercraft Vehicle Specifications and Operation

a) All watercraft shall meet the requirements of Article IV of the Boat Registration and Safety Act.
b) All watercraft shall carry equipment including but not limited to the following:
1) One anchor with line attached that is three times the maximum depth of water in the areas of usual operation,
2) Two docking fenders,
3) Two mooring lines,
4) Self or mechanical bailer,
5) Search light with a minimum of 200,000 candle power,
6) Swim harness attached to 75 feet of tethering line,
7) Waterproof flashlight, six volt minimum,
8) Basic tool kit, to include at least:
A) Wrench, 12 inch with adjustable open end,
B) Screw driver, 12 inch with straight blade,
C) Locking pliers, minimum length, ten inches,
9) One life jacket for each member of the watercraft crew and two extra adult life jackets,
10) Two child life jackets,
11) Knife, six-inch blade, with sheath,
12) Boat hook, extendable to at least ten feet,
13) A locking mechanism to secure a stretcher or litter below the gunwale level,
14) For watercraft operating on Lake Michigan:
A) A UHF/FM marine radio with at least 25 watts of power,
B) Loran Navigational Aid,
C) Navigational charts for service area and navigational aids, including compass, and
D) Speed capability of 20 knots per hour.
c) All watercraft shall have communication equipment to assure exchange of information between individuals and agencies, including at least those involved at the SEMSV medical control point within the EMS System, and law enforcement agencies.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.975 Watercraft Medical Equipment and Drugs

a) Each watercraft shall be equipped with medical equipment and drugs that are appropriate for the various types of missions to which it

will be responding, as specified by the SEMSV Medical Director.

b) For ALS operations, the SEMSV Medical Director shall submit for approval a list of supplies available for each mission used. The SEMSV Medical Director shall decide on the medical equipment and drugs taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

c) The Department's approval shall be based on, but not limited to:

1) length of time of the mission;
2) possible environmental or weather hazards;
3) number of individuals served; and
4) medical condition of individuals served.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.980 Watercraft Communications and Dispatch Center

a) The SEMSV Program shall have a designated dispatch center assigned and available 24 hours per day every day of the year to receive and dispatch all requests for watercraft services.

b) The communications and dispatch center shall have the ability to communicate with the watercraft for non-medical purposes on a separate designated frequency.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.985 Off-Road SEMSV Requirements

In addition to the requirements specified in Sections 515.900 and 515.920 of this Part, an SEMSV Program utilizing off-road SEMS vehicles shall submit a Program Plan that includes the following:

a) Documentation of the Medical Director's credentials as required by Section 515.920(e) of this Part, and a statement signed by the Medical Director containing his or her commitment to the following duties and responsibilities:

1) The supervision and management of the program;
2) Supervising and evaluating the quality of patient care provided by the off-road SEMSV crew;
3) Providing medical advice/expertise on the use, need and special requirements of off-road SEMSV transfer;
4) Submitting documentation assuring the qualifications of the off-road SEMSV crew; and
5) Assuring appropriate staffing of the off-road SEMS vehicle:
   A) For Advanced Life Support (ALS) operations, the vehicle shall be staffed by a minimum of one EMT-P, registered nurse or physician and one other EMT, registered nurse or physician, one of whom may also be the driver of the off-road SEMS vehicle; and
   B) For Basic Life Support (BLS) operations, the vehicle shall be staffed by a minimum of two EMTs, registered nurses or physicians, one of whom may also be the driver of the off-road SEMS vehicle;

b) The SEMSV Medical Director's list of required medical equipment and drugs for use on the off-road SEMSV (see Section 515.995 of this Part);

c) The SEMSV Medical Director's standing orders (treatment protocols, standard operating procedures);

d) A description of the communications system linking the off-road SEMSV with the SEMSV medical control point;

e) A description and map of the service area for each vehicle;

f) The identification number and description of all vehicles used in the program;

g) An agreement/contract with a licensed ground provider for transportation of patients; and

h) A description of the EMS System's method of providing emergency medical services using the SEMSV Program.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.990 Off-Road Vehicle Specifications and Operation

a) The off-road SEMSV shall have sufficient space for the vehicle operator, a patient in a supine position, and personnel rendering medical care alongside the patient.

b) Each vehicle shall have a locking mechanism to secure the litter/stretcher or backboard to the off-road SEMSV.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.995 Off-Road Medical Equipment and Drugs

a) Each off-road SEMSV shall be equipped with medical equipment and drugs for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.

b) For Advanced Life Support (ALS) operations, the SEMV Medical Director shall submit for approval a list of supplies available for each mission. The SEMSV Medical Director shall decide what medical equipment and drugs are taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route.

(Source: Added at 20 Ill. Reg. _____, effective

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Section 515.1000 Off-Road Communications and Dispatch Center

a) The SEMSV Program shall have a designated dispatch center assigned and available 24 hours per day every day of the year to receive and dispatch all requests for off-road SEMSV services.

b) The communications and dispatch center shall have the ability to communicate with the off-road SEMSV for non-medical purposes on a separate designated frequency.

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART H: TRAUMA CENTERS

Section 515.2000 Trauma Center Designation

a) *The Department shall attempt to designate trauma centers in all areas of the State. There shall be at least one Level I Trauma Center serving each EMS Region, unless waived by the Department. Level I Trauma Centers shall serve as resources for Level II Trauma Centers in the EMS Regions. The extent of such relationships shall be defined in the EMS Region plan.* (Section 3.90(b)(5) of the Act)

b) Any hospital seeking designation as a Level I or Level II Trauma Center shall submit an application form (see Section 515.Appendix A of this Part) as prescribed by the Department.

c) *Upon receipt of a completed* application, the Department shall *conduct a site visit to* determine compliance with the Act and this Part. *A report of the inspection shall be provided to the Director within 30 days of the completion of the site visit.* (Section 3.90(b)(3) of the Act)

d) *The Department shall designate* those *applicant hospitals as Level I or Level II Trauma Centers* which *meet the* requirements *established by* the Act and this Part. *Beginning September 1, 1997 the Department shall designate a new Trauma Center only when a local or regional need for such a Trauma Center has been identified* by the *applicable EMS Region's Trauma Center Medical Directors Committee, with advice from the Regional Trauma Advisory Committee.* (Section 3.90(b)(4) of the Act)

e) A Trauma Center designation shall be for two years.

f) All requests for renewal of Trauma Center designations shall be filed in writing with the Department before the designation expiration date. If the renewal request meets the requirements of this Part, the existing designation shall continue in full force and effect until a final Department decision on the renewal request has been issued.

g) Any level Trauma Center may voluntarily terminate its designation prior to its expiration date by notifying the Department in writing.

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Such notification shall include the anticipated date of termination, which shall not exceed 60 days after notice is received by the Department, and shall describe the procedures taken by the Trauma Center to notify the providers, hospitals, EMS systems and other Trauma Centers in the EMS Region.

h) *No facility shall use the phrase "Trauma Center" or words of similar meaning in relation to itself or hold itself out as a Trauma Center without first obtaining designation pursuant to the Act and this Part.* (Section 3.105 of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2010 Denial of Application for Designation or Request for Renewal

a) The Department shall deny an application for designation or a request for renewal of a designation when its findings show failure to substantially comply with the Act or this Part;

b) The Department shall review a trauma center whose annual morbidity and mortality fall two standard deviations above the mean.

c) The Department shall provide written notice, via certified mail, of its decision to deny an application for designation or a request for renewal of a designation. The applicant shall have 15 days after receipt of the written notice to make a written request for an administrative hearing to contest the Department's decision. All administrative hearings shall be conducted in accordance with the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100).

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2020 Inspection and Revocation of Designation

a) *The Department shall have the authority to inspect designated trauma centers to assure compliance with the provisions of* the Act and this Part. *Information received by the Department through filed reports, inspection or as otherwise authorized under* the Act *shall not be disclosed publicly in such a manner as to identify individuals or hospitals, except in a proceeding involving the denial, suspension or revocation of a trauma center designation or imposition of a fine on a trauma center.* Section 3.90(b)(6) of the Act)

b) *The Department shall have the authority to take the following action, as appropriate, after determining that a trauma center is in violation of* the Act or this Part:

1) *If the Director determines that the violation presents a substantial probability that death or serious physical harm will result and if the trauma center fails to eliminate the violation*

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immediately or within a fixed period of time, not exceeding 10 days, as determined by the Director, the Director may immediately revoke the trauma center designation. The trauma center may appeal the revocation within 15 days after receiving the Director's revocation order by requesting a hearing as provided by Section 3.135 of the Act. The Director shall notify the chair of the Region's Trauma Center Medical Directors Committee and EMS Medical Directors for the appropriate EMS Systems of such a trauma center designation revocation.

2) *If the Director determines that the violation does not present a substantial probability that death or serious physical harm will result, the Director shall issue a notice of violation and request a plan of correction which shall be subject to the Department's approval. The trauma center shall have 10 days after the receipt of the notice of violation in which to submit a plan of correction. The Department may extend this period for up to 30 days.* Section 3.90(b)(10)(B) of the Act)

A) The Department will consider the following factors in determining whether or not to extend the period for submission of the plan of correction to a maximum of 30 days: whether a substantial probability that death or serious physical harm will result still exists, and whether the delay could lead to physical harm.

B) *The plan shall include a fixed time period not in excess of 90 days within which violations are to be corrected. The plan of correction and the status of its implementation by the trauma center shall be provided, as appropriate, to the EMS Medical Directors for the appropriate EMS Systems. If the Department rejects a plan of correction, it shall send notice of the rejection and the reason for the rejection to the trauma center. The trauma center shall have 10 days after receipt of the notice of rejection in which to submit a modified plan. If the modified plan is not timely submitted, or if the modified plan is rejected, the trauma center shall follow an approved plan of correction imposed by the Department. If, after notice and opportunity for hearing, the Director determines that a trauma center has failed to comply with an approved plan of correction, the Director may revoke the trauma center designation. The trauma center shall have 15 days after receiving the Director's notice in which to request a hearing. Such hearing shall conform to the provisions of Section 3.135 of the Act.* Section 3.90(b)(10)(B) of the Act)

C) Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences which are the basis of the violation and an evaluation of the practices, policies, and procedures which have caused or contributed to the conditions or occurrences. Evidence of such assessment

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and evaluation shall be maintained by the facility. Each plan shall include:

i) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice;

ii) A description of the steps that will be taken to avoid future occurrences of the same or similar violations.

D) The Department shall review each plan of correction to ensure that it provides for the abatement, elimination, or correction of the violation. The Department shall reject a submitted plan if it finds any of the following deficiencies:

i) The plan does not address the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences;

ii) The plan is not specific or does not provide measures to indicate the actual actions the facility will be taking to abate, eliminate, or correct the violation(s).

iii) The plan does not provide steps that will avoid future occurrences of the same and similar violations.

iv) The plan does not provide for timely completion of the corrective action, considering the seriousness of the violation, any possible harm to patients, and the extent and complexity of the corrective action.

E) The Department shall verify the completion of the corrective action:

i) By requiring the trauma center to submit monthly reports to the Department for up to one year, which consists of current hospital trauma plan (first month only); trauma quality monitoring plan and indicators (first month only); minutes of all meetings pertaining to trauma, including but not limited to Trauma Service Committee, Department of Surgery, and Morbidity and Mortality Review Committee; a list of all Category I and II trauma patients treated in the previous month, which includes but is not limited to medical record number, date and time of arrival at the trauma center, sex, mechanism of injury, trauma category classification and time; trauma surgeon and surgical specialty time of notification and arrival time; and

ii) Through subsequent investigations, surveys and evaluations of the trauma center.

(Source: Added at 20 Ill. Reg. _____, effective

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Section 515.2030 Level I Trauma Center Designation Criteria

a) The Level I Trauma Center, under the direction of the Level I Trauma Center Medical Director, shall be responsible for the coordination and management of trauma care in the EMS Region. This responsibility includes obtaining the cooperation of all Level II Trauma Centers, Affiliate Trauma Hospitals, and EMS Systems in the EMS Region. A Level I Trauma Center Medical Director shall be the chairperson of the Regional Trauma Advisory Committee.

b) The Trauma Center Medical Director shall be a trauma surgeon, board certified in surgery, with at least one year of experience in trauma care and with 24-hour independent operating privileges.

c) The trauma center shall provide a trauma service separate from the general surgery service, which is an identified hospital service functioning under a designated director and staffed by trauma surgeons with one year of experience in trauma, and who are available in-house 24 hours a day.

1) The trauma surgeon requirement may be fulfilled by residents with a minimum of four years of general surgery residency training with independent operating room privileges.

2) If the resident is fulfilling the trauma surgeon requirement, the attending physician must be consulted within 30 minutes after the patient being classified as Category I or II.

3) If the resident is fulfilling the trauma surgeon requirement, it is mandatory that an attending be present for Category I patients 30 minutes after the decision to operate is made.

4) The trauma surgeon, resident or surgical subspecialist will be consulted when the decision is made to admit a Category II patient. The trauma surgeon or appropriate subspecialist will see the patient within 12 hours after Emergency Department (ED) arrival.

5) The hospital's quality improvement program shall monitor compliance with this subsection.

d) The trauma center shall have the following surgical services:

1) On call to arrive at the hospital to treat the patient within 30 minutes after notification that their services are needed at the hospital:

A) Cardiothoracic: this requirement may be fulfilled by a cardiothoracic surgeon or a trauma/general surgeon with experience in cardiothoracic surgery for lifesaving procedures; the surgeon must have cardiothoracic privileges;

B) Obstetrics; and

C) Pediatric surgery.

2) On call to arrive at the hospital to treat the patient within 60 minutes after notification that their services are needed at the hospital:

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A) Orthopedic;

B) Vascular;

C) Ophthalmologic;

D) Oral-Dental;

E) Otorhinolaryngologic;

F) Plastic/maxillofacial;

G) Urologic;

H) Reimplantation service, or a transfer agreement; and

I) Neurosurgery.

3) Twenty-four hours a day, or a transfer agreement:

A) Burn center staffed by Registered Nurses trained in burn care; and

B) Acute spinal cord injury management.

e) The trauma center shall provide the following nonsurgical services within the designated times:

1) Emergency Medicine staffed 24 hours a day in the ED by:

A) A physician who has competency in trauma as demonstrated by:

i) Board certification by the ABEM; or

ii) Completion of 12 months of internship, followed by at least 7000 hours of hospital-based Emergency Medicine over at least a 60-month period (including 2800 hours within one 24-month period), verified in writing by the hospital(s) at which the internship and subsequent hours were completed, and continuing medical education totalling 50 hours for each post-internship year in which the physician completed any hospital-based Emergency Medicine hours (the physician may attend less than 50 hours in any given year provided the total number averages 50 hours per year of practice); or

iii) Completion of a residency in Emergency Medicine in a residency program approved by the Residency Review Committee for Emergency Medicine; and

B) An osteopathic physician certified by the AOBEM by the AOA.

2) Anesthesiology Services:

A) The anesthesiology service or department shall be supervised by anesthesiologists. 'Supervise', for the purposes of this subsection, means to manage, control and direct the services performed, including being present in the trauma center and immediately available for consultation while the services are being performed.

B) Anesthesiology services shall be available 24 hours a day in-house.

C) Direct patient care services may be performed by an anesthesiologist or a certified registered nurse anesthetist (CRNA) acting under the direct supervision of an anesthesiologist.

3) Radiology staffed by:

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A) A technician with the ability to perform a computerized axial tomography (CAT) scan in-house.

B) A radiologist with the ability to read CAT scans and perform angiography available within 30 minutes. This requirement may be met by a Post Graduate Year (PGY) II radiology resident or a PGY I resident with six months experience in CAT and angiography. Teleradiographic equipment may be used to transmit CAT scans to radiologists off site in lieu of the radiologists response to the trauma center to read CAT scans. The radiology department shall provide a quality monitoring process to validate the resident's compliance with the time requirements and competency to read CAT scans and perform angiography.

4) Intensive Care Medicine Unit having available 24 hours a day in-house:

A) A physician credentialed by the hospital. This requirement may be fulfilled by second and third year residents who have had adult intensive care training and are under the supervision of a staff physician possessing full adult intensive care privileges;

B) Registered Professional Nurses; and

C) The following equipment:

i) Airway control and ventilation devices;

ii) Oxygen source with concentration controls;

iii) Cardiac emergency cart;

iv) Electrocardiograph-oscilloscope-defibrillator;

v) Cardiac output monitoring;

vi) Electronic pressure monitoring;

vii) Mechanical ventilator-respirators;

viii) Pulmonary function measuring devices;

ix) Temperature control devices;

x) Drugs, intravenous fluids, and supplies in accordance with the Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically 250.1050, 250.2140, and 250.2710;

xi) Intracranial pressure monitoring devices; and

xii) Intra-aortic balloon pump capability.

5) Laboratory 24 hours a day in-house, providing the following:

A) Standard analysis of blood, urine, and other body fluids;

B) Blood typing and cross-matching;

C) Coagulation studies;

D) Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities (see Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically 250.520);

E) Blood gases and pH determinations;

F) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a 24 hour per day basis; and

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G) Drug and alcohol screening.

6) Cardiology -- 60 minutes;

7) Internal Medicine -- 60 minutes;

8) Neuroradiology staffed by a radiologist with the ability to read CAT scans and perform angiography -- 30 minutes; this requirement may be met by a PGY II radiology resident or PGY I resident with six months experience in CAT and angiography;

9) Pediatrics -- 60 minutes;

10) Postanesthetic recovery capabilities 24 hours a day; and

11) Acute hemodialysis capability 24 hours a day or a transfer agreement.

g) The trauma center shall meet the following professional staff requirements:

1) The ED Director shall be a physician board certified by the ABEM or certified by the AOBEM by the AOA;

2) Each shift in the ED will be staffed by at least one Registered Nurse who has completed a Trauma Nurse Specialist Course as specified in Section 515.750 of this Part. A back-up policy shall provide for a nurse with experience evidenced by successful completion of an institution orientation to trauma care in addition to a current Trauma Nurse Core Curriculum (TNCC) or 16 hours equivalent in trauma nursing education, approved by the Department, in a four-year period. A back-up schedule must be maintained;

3) Trauma Coordinator dedicated to the Trauma Program; and

4) An operating room shall be staffed in-house and available 24 hours a day.

h) The trauma center shall provide and maintain the following equipment:

1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen, and mechanical ventilator;

2) Suction devices and equipment (pulmonary and gastric);

3) Electrocardiograph-oscilloscope-defibrillator;

4) Apparatus to establish central venous pressure monitoring;

5) All standard intravenous fluids and administration devices;

6) Sterile surgical instruments or sets for emergency care, such as cricothyrotomy, tracheostomy, thoracotomy, thoracostomy, and cut down;

7) Drugs and supplies necessary for emergency care;

8) X-ray and CAT scan capability;

9) Spinal immobilization equipment;

10) Temporary pacemaker; and

11) Specialized pediatric resuscitation cart in the Emergency Area.

i) The trauma center must have helicopter landing capabilities approved by State and federal authorities. Section 3.35(i) of the Act) The helicopter landing capabilities shall:

1) Comply with the Aviation Safety Rules of the Illinois Department of Transportation (92 Ill. Adm. Code 14, specifically 14.790,

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14.792, and 14.795);

2) Be covered by a favorable airspace determination letter issued by the Federal Aeronautics Administration pursuant to Sections 307 and 309 of the Federal Aviation Act of 1958, and 14 CFR 157 and 14 CFR 77, Subpart D;

3) Be provided on the campus of the Trauma Center; and

4) Out-of-state trauma centers are exempted from this subsection but must provide proof of compliance with their state's rules that govern aviation safety.

j) The trauma center shall perform focused outcome analyses of its trauma services on a quarterly basis, and shall provide on site or upon request all minutes related to these reviews at the request of the Department. The analyses shall consist of at least:

1) Review of all patient deaths, excluding dead on arrival (DOA). Patients must be assigned a status of non-preventable death, potentially preventable death, or preventable death using the American College of Surgeons "Guidelines for Judgment Regarding Mortality" from "Resources for Optimal Care of the Injured Patient"). Factors contributing to the death must be included in the review according to the American College of Surgeons "Contributing Factors and Guidelines for Assigning Contributing Factors Related to Morbidity/Mortality" (from "Resources for Optimal Care of the Injured Patient"). A cumulative report of these findings should be kept on site and available to the Department upon request.

2) Review of all morbidities. A morbidity is a negative outcome that is the result of the original trauma and/or treatment rendered or omitted. Factors contributing to the morbidity must be included in the review according to the American College of Surgeons "Contributing Factors and Guidelines for Assigning Contributing Factors Related to Morbidity/Mortality." A cumulative report of these findings must be presented quarterly to the region.

3) Review of audit filters. An audit filter is a clinical and/or internal resource indicator used to examine the process of care and to identify potential patient care and/or internal resource problems.

4) *All information contained in or relating to any medical audit performed of a trauma center's trauma services pursuant to the Act or by an EMSMD or his designee of medical care rendered by system personnel, shall be afforded the same status as is provided information concerning medical studies in article VIII, Part 21 of the Code of Civil Procedure.* (Section 3.110(a) of the Act)

k) Every two years the trauma center shall provide written protocols with the redesignation packet, which shall include the following:

1) The protocols and policies for treating patients in the Level I Trauma Center, which include Trauma Category I and Trauma

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Category II criteria as required in Section 515.Appendices C and F of this Part;

2) The protocols for transferring trauma patients to more specialized care;

3) A policy that a blood alcohol test will be drawn on any motor vehicle crash victim who is believed to have been the driver of the vehicle.

l) Changes to the Trauma Center Plan must be approved by the Department prior to implementation.

m) The practices of the trauma center shall reflect the protocols and policies of the EMS Region and Trauma Center plan.

n) The resuscitation care of a Trauma Category I or Trauma Category II patient must be documented on a Trauma Flow Sheet, which at minimum contains trauma category classification; time and place of classification (field or in-house); time of arrival of patient to trauma center; notification of surgical specialties and time of arrival to see patient (may exclude isolated injuries for Category II patients).

o) The trauma center shall maintain a job description for the Trauma Center Medical Director, which details his/her responsibility and authority for the coordination and management of trauma services.

p) The trauma center shall maintain a job description for the Trauma Coordinator, which details his/her responsibility and authority for the coordination and management of trauma services.

q) The trauma center shall develop a policy that identifies resource limitations that would result in the diversion of a trauma patient to another facility. This policy shall include notification of procedures for pre-hospital personnel and surrounding trauma centers.

1) Such diversion must be reported to the Department by telephone if it occurs during business hours. Otherwise, written notification of diversion must be sent no more than 48 hours following the diversion.

2) Both forms of notification shall include at minimum:

A) The name of the trauma center;

B) Date and time of resource limitation; and

C) The reason for resource limitation.

r) The trauma center shall develop a plan for implementing a program of public information and education concerning trauma care for adult and pediatric patients.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2040 Level II Trauma Center Designation Criteria

a) A Level II Trauma Center, under the direction of a Level II Trauma Center Medical Director, shall be responsible for providing trauma care in accordance with the EMS System Program Plan.

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b) The Trauma Center Medical Director shall be a trauma surgeon, board certified in surgery, with at least one year of experience in trauma care and with 24-hour independent operating privileges.

c) The trauma center shall provide a trauma service separate from the general surgery service, which is an identified hospital service functioning under a designated director and staffed by trauma surgeons with one year of experience in trauma, and who will arrive at the hospital to treat the trauma patient within 30 minutes of the patient being classified as a Category I trauma patient.

1) The trauma surgeon requirement may be fulfilled by residents with a minimum of four years of general surgery residency training with independent operating room privileges.

2) If the resident is fulfilling the trauma surgeon requirement, the attending physician must be consulted within 30 minutes of the patient being classified as Category I or II.

3) If the resident is fulfilling the trauma surgeon requirement, it is mandatory that an attending be present for Category I patients undergoing operative procedures by the time the surgery begins.

4) The trauma surgeon or resident will be consulted when the decision is made to admit a Category II patient. The trauma surgeon or appropriate subspecialist will see the patient within 12 hours after ED arrival.

5) The hospital's quality improvement program shall monitor compliance with this subsection.

6) The trauma center shall maintain a call schedule that identifies at least a primary and back-up surgeon, each listed by surgeon's name.

7) The trauma center shall have the option of allowing the ED personnel to determine that a trauma patient with an isolated injury may be treated by one of the services listed in subsection (d) or (e) of this Section. Any patient meeting the definition of isolated injury below requires consultation with the appropriate subspecialist, except for neurosurgical injury, within 60 minutes after the notification that his or her services are needed at the hospital or initiation of specialty center transfer within 30 minutes after arrival and transfer completed within two hours. On those occasions wherein the need for operative intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. An isolated injury refers to the transfer of energy to a single specific anatomic body region with no potential for multisystem involvement.

d) The trauma center shall have the following surgical services on call to arrive at the hospital to treat the patient within 60 minutes after notification that their services are needed:

1) Cardiothoracic; this requirement may be fulfilled by a cardiothoracic surgeon or a trauma/general surgeon with

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experience in cardiothoracic surgery for lifesaving procedures; the surgeon must have cardiothoracic privileges;

2) Obstetrics;

3) Orthopedic; and

4) Urologic.

e) The trauma center shall have the following surgical specialties on call to arrive at the hospital to treat the patient within 60 minutes after notification that their services are needed. These services may be provided by written transfer agreement. These services must be provided according to subsection (c)(7) of this Section for isolated injuries when the trauma surgeon is not required to respond:

1) Neurosurgical;

2) Ophthalmologic;

3) Oral-Dental;

4) Otorhinolaryngologic;

5) Reimplantation;

6) Plastic Maxillofacial;

7) Burn center staffed by Registered Nurses trained in burn care;

8) Acute spinal cord injury management; and

9) Pediatric surgery.

f) The trauma center shall provide the following nonsurgical services within the designated times:

1) Emergency Medicine staffed 24 hours a day in the ED by:

A) A physician who has competency in trauma as demonstrated by:

i) Board certification by the ABEM; or

ii) Completion of 12 months of internship, followed by at least 7000 hours of hospital-based Emergency Medicine over at least a 60-month period (including 2800 hours within one 24-month period), verified in writing by the hospital(s) at which the internship and subsequent hours were completed, and continuing medical education in Emergency Medicine totalling 50 hours for each post-internship year in which the physician completed any hospital-based Emergency Medicine hours. The physician may attend less than 50 hours in any given year provided the total number averages 50 hours per year if practice); or

iii) Completion of a residency in Emergency Medicine in a residency program approved by the Residency Review Committee for Emergency Medicine; and

B) An osteopathic physician certified by the AOBEM by the AOA.

2) Anesthesiology Services:

A) Anesthesiology services shall be in compliance with the Hospital Licensing Act and the Hospital Licensing Requirements, 77 Ill. Adm. Code 250.1410. Staff shall be on call to arrive at the hospital to administer anesthesia within 30 minutes after notification that their services are needed at the hospital.

B) Direct patient care services may be performed by an anesthesiologist or a CRNA.

3) Laboratory -- 24 hours a day in-house, providing the following:
   A) Standard analysis of blood, urine, and other body fluids;
   B) Blood typing and cross-matching;
   C) Coagulation studies;
   D) Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities (see Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically Section 250.920);
   E) Blood gases and pH determinations;
   F) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a 24 hour per day basis; and
   G) Drug and alcohol screening.
4) Radiology staffed by:
   A) A technician with the ability to perform a CAT scan available within 30 minutes; and
   B) A radiologist with the ability to read CAT scans and perform angiography available within 60 minutes. This requirement may be met by a PGY II radiology resident or PGY I resident with six months experience in CAT and angiography. The radiology department shall provide a quality monitoring process to validate the resident's compliance with the time requirements and competency to read CAT scans and perform angiography. Teleradiographic equipment may be used to transmit CAT scans off site in lieu of radiologists' response to the trauma center to read CAT scans.
5) Cardiology -- 60 minutes.
6) Internal Medicine -- 60 minutes.
7) Postanesthetic recovery capability staffed and available with 30 minutes.
8) Intensive Care Medicine Unit having available the following:
   A) A physician credentialed by the hospital and available within 30 minutes. This requirement may be fulfilled by second and third year residents who have had adult intensive care training and are under the supervision of a staff physician possessing full adult intensive care privileges;
   B) Registered Professional Nurses 24 hours a day in the Intensive Care Unit; and
   C) The following equipment 24 hours a day in-house:
      i) Airway control and ventilation devices;
      ii) Oxygen source with concentration controls;
      iii) Cardiac emergency cart;
      iv) Electrocardiograph-oscilloscope-defibrillator;
      v) Temperature control devices;
      vi) Drugs, intravenous fluids, and supplies in accordance with the Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically Sections 250.1050, 250.2140, and 250.2710; and
      vii) Mechanical ventilator-respirators.
9) Pediatrics -- 60 minutes.
10) Acute hemodialysis capability 24 hours a day or a transfer agreement.

g) The trauma center shall meet the following professional staff requirements:
   1) The ED Director shall be a physician board certified by the ABEM, or a physician who has completed 12 months of internship, followed by 60 months plus 7000 hours of hospital-based Emergency Medicine (2800 of the 7000 hours must be completed within one 24-month period), and 50 hours of continuing medical education in Emergency Medicine for each complete year of practice, or a physician who has completed a residency program approved by the Residency Review Committee for Emergency Medicine or by the AOA;
   2) Each shift in the ED will be staffed by at least one Registered Nurse who has completed a Trauma Nurse Specialist Course as specified in Section 515.750 of this Part. A back-up policy shall provide for a nurse with experience evidenced by TNCC or 16 hours equivalent in trauma nursing education, approved by the Department, in a four-year period. A back-up schedule must be maintained;
   3) A Trauma Coordinator dedicated to the Trauma program; and
   4) An operating room shall be staffed and available within 30 minutes 24 hours a day.

h) The trauma center shall provide and maintain the following equipment:
   1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen, and mechanical ventilator;
   2) Suction device;
   3) Electrocardiograph-oscilloscope-defibrillator;
   4) Apparatus to establish central venous pressure monitoring;
   5) All standard intravenous fluids and administration devices;
   6) Sterile surgical sets of procedures standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, and cut down;
   7) Gastric lavage equipment;
   8) Drugs and supplies necessary for emergency care;
   9) X-ray and CAT scan capability, available within 30 minutes;
   10) Spinal immobilization equipment;
   11) Temporary pacemaker; and
   12) Specialized pediatric resuscitation cart in the Emergency Area.

i) The trauma center must have helicopter landing capabilities approved by State and federal authorities. Section 3.100(7) of the Act) The helicopter landing capabilities shall:
   1) Comply with the Aviation Safety Rules of the Illinois Department of Transportation (92 Ill. Adm. Code 14, specifically Sections 14.790, 14.792 and 14.795);
   2) Be covered by a favorable airspace determination letter issued by

the Federal Aeronautics Administration pursuant to Sections 307 and 209 of the Federal Aviation Act of 1958, and 14 CFR 157 and 14 CFR 77, Suppart D;

3) Be provided on the campus of the trauma center; and

4) Out-of-state trauma centers are exempted from this subsection but must comply with their state's rules that govern aviation safety.

i) The trauma center shall perform focused outcome analyses of its trauma services on a quarterly basis and shall provide all minutes related to these reviews at the request of the Department. The analyses shall consist of at least:

1) Review of all patient deaths, excluding dead on arrival (DOA). Patients must be assigned a status of non-preventable death, potentially preventable death, or preventable death using the American College of Surgeons "Guidelines for Judgment Regarding Mortality" (from "Resources for the Optimal Care of the Injured Patient"). Factors contributing to the death must be included in the review according to the American College of Surgeons "Contributing Factors and Guidelines for Assigning Contributing Factors Related to Morbidity/Mortality" (from "Resources for the Optimal Care of the Injured Patient"). A cumulative report of these findings shall be available on site and upon request by the Department.

2) Review of all morbidities. A morbidity is a negative outcome that is the result of the original trauma and/or treatment rendered or omitted. Factors contributing to the morbidity must be included in the review according to the American College of Surgeons "Contributing Factors and Guidelines for Assigning Contributing Factors Related to Morbidity/Mortality." A cumulative report of these findings must be presented quarterly to the region.

3) Review of audit filters. An audit filter is a clinical and/or internal resource indicator used to examine the process of care and to identify potential patient care and/or internal resource problems.

4) *All information contained in or relating to any medical audit performed of a trauma center's trauma services pursuant to the Act or by an EMSMD or his designee of medical care rendered by system personnel, shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure.* Section 3.110(a) of the Act)

k) Every two years the trauma center shall provide written protocols concerning the following:

1) The treatment of trauma patients in the trauma center, which includes Trauma Category I and Trauma Category II criteria as required in Section 515.Appendices C and F of this Part;

2) The transfer of trauma patients to the Level I Trauma Center serving the EMS Region or a more specialized level of care;

3) A policy that blood alcohol will be drawn on a motor vehicle crash victim who is believed to have been the driver of the vehicle.

l) Changes to the Trauma Center Plan must be approved by the Department prior to implementation.

m) The practices of the trauma center shall reflect the protocols and policies of the EMS Region and Trauma Center Plan.

n) The resuscitation care of a Trauma Category I or Trauma Category II patient must be documented on a Trauma Flow Sheet, which at minimum contains trauma category classification; time and place of classification (field or in-house); time of arrival of patient to trauma center; notification of surgical specialties and time of arrival to see patient may exclude isolated injuries for Category II patients).

o) The trauma center shall maintain a job description for the Trauma Center Medical Director, which details his/her responsibility and authority for the coordination and management of trauma services.

p) The trauma center shall maintain a job description for the Trauma Coordinator, which details the responsibility and authority for the coordination and management of trauma services.

q) The trauma center shall develop a policy that identifies situations that would result in trauma bypass. This policy shall include notification of procedures for pre-hospital personnel and surrounding trauma centers.

1) Such diversion must be reported to the Department by telephone if it occurs during business hours. Otherwise, written notification of diversion must be sent no more than 48 hours following the diversion.

2) Both forms of notification shall include at minimum:

A) The name of the trauma center;

B) Date and time of resource limitation; and

C) The reason for resource limitation.

r) The trauma center shall develop a plan for implementing a program of public information and education concerning trauma care for adult and pediatric patients.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2050 Trauma Center Uniform Reporting Requirements

a) Each trauma center shall have available to the Trauma Service use of a Microsoft Disc Operating System (MS-DOS) version 6.0, IBM compatible personal computer that meets the following standards: 486 microprocessor, eight megabytes Random Access Memory (RAM), adequate hard drive space to accommodate the trauma center's data files and needs, at least 14.4kbs modem, color monitor, printer and back-up capability. The Department shall provide Trauma Registry software for

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use by the trauma center. This software shall be used for data collection and shall have a provision to prepare electronic media reports to the Department on a quarterly basis.

b) The trauma center shall provide the following information on each reportable trauma patient:
   1) Registry Number;
   2) Medical Record Number;
   3) Name (first and last);
   4) Address, city, state, county and zip;
   5) EMS Region;
   6) Age;
   7) Sex;
   8) Race;
   9) Injury Type;
   10) Mechanism of Injury (International Classification of Disease (ICD) 9 Ecodes - 4 digits);
   11) Safety Equipment;
   12) Hospital Transfer From and Hospital Transfer To;
   13) Transport Mode;
   14) Run Sheet;
   15) Date Arrived At Scene (only for when pre-hospital transport is involved);
   16) ED Arrival Date;
   17) ED Disposition Date;
   18) Glasgow Coma Scale Components (Eye, Motor, Verbal and Total) in ED;
   19) First Temperature in ED;
   20) ED Blood Pressure, Pulse, Respiratory Rate;
   21) ED Revised Trauma Score;
   22) ED Triage Category;
   23) Minimum Field Triage Criteria;
   24) ED Treatment;
   25) Blood Alcohol Level in all drivers in motor vehicle crashes;
   26) Blood Units Administered;
   27) Physician Type, Notification Time, Arrival Time;
   28) Admitting Service;
   29) Medical Complications;
   30) Total ICU Days, Monitored Bed Days and Unmonitored Bed Days;
   31) Number of Ventilator Days;
   32) Surgery Performed, Surgery Date;
   33) Additional Surgeries;
   34) Abbreviated Injury Scale for each injury;
   35) Injury Severity Score (ISS) range 1-75;
   36) Primary Pay Source;
   37) Discharge Condition and Date; and
   38) Total Hospital Days.

c) Reportable trauma patients
   1) A reportable trauma patient is one who was involved in a traumatic event and:
      A) was transferred to the trauma center from another hospital;
      B) was transferred from the trauma center to another hospital;
      C) was admitted to the trauma center as an inpatient;
      D) was assigned an observation status and had a length of stay greater than 12 hours from time of arrival in the ED;
      E) was dead on arrival (DOA);
      F) died in the emergency department (DIE); or
      G) signed out against medical advice after refusing admission (AMA).
   2) A traumatic event is one in which there was a transfer of energy resulting in injury, involving any of the following:
      A) aircraft;
      B) watercraft;
      C) motor vehicles;
      D) railway;
      E) recreational vehicles;
      F) farm machinery;
      G) animals, including bites;
      H) explosion;
      I) falls;
      J) thermal (including smoke inhalation)/chemical/radiation injuries;
      K) lightning;
      L) weather related (tornado, flood, blizzard) injuries;
      M) struck by falling object;
      N) sports related;
      O) caught between objects;
      P) cutting or piercing instruments or objects;
      Q) firearms;
      R) electric current;
      S) suicide or self-inflicted injury;
      T) homicide;
      U) injury inflicted by others;
      V) hanging; or
      W) strangulation.

d) Illinois trauma registry reporting schedule

Patients Discharged	Report Date
January - March	June 30
April - June	September 30
July - September	December 31
October - December	March 31

e) Data shall be collected for all trauma patients in the State for each level of Injury Severity Score mean mortality rates, and standard deviations shall be calculated using standard statistical methods. Trauma centers with mortality rates more than one standard deviation above the mean in three or more ISS levels shall have an in-depth

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evaluation by the Department prior to renewal of designation. Trauma centers with mortality rates more than two standard deviations above the mean in any ISS level less than 25 shall also be evaluated for compliance with the Act and this Part prior to renewal of designation.

f) Data collected from individual trauma centers shall be cross-referenced with Vital Records Death Certificates to confirm accuracy.

g) Annual reports shall be prepared by the Department presenting summary data to allow trauma centers to evaluate performance. This data shall have all hospital and patient identifiers removed.

h) All data received by the Department shall be kept confidential. Patient identifiers shall be kept in such a way to assure that confidentiality is maintained and is not available to the public.

1) *All reports and records made pursuant to the* Head and Spinal Cord Injury Act (410 ILCS 515) *and maintained by the Department and other appropriate persons, officials and institutions pursuant to the* Head and Spinal Cord Injury Act *shall be confidential. Information shall not be made available to any individual or institution except to:*

A) *Appropriate staff of the department;*

B) *Any person engaged in a bona fide research project, with the permission of the Director of Public Health, except that no information identifying the subjects of the reports or the reporters shall be made available to researchers unless the Department requests and receives consent for such release pursuant to the provisions of this Section; and*

C) *The council, except that no information identifying the subjects of the reports or the reporters shall be made available to the council unless consent for release is requested and received pursuant to the provisions of this Section. Only information pertaining to head and spinal cord injuries as defined in Section 1 of the* Head and Spinal Cord Injury Act *shall be released to the council.* (Section 3 of the Head and Spinal Cord Injury Act)

2) *The Department shall not reveal the identity of a patient, physician or hospital, except that the identity of the patient may be released upon written consent of the patient, parent or guardian, the identity of the physician may be released upon written consent of the physician, and the identity of the hospital may be released upon written consent of the hospital.* (Section 3 of the Head and Spinal Cord Injury Act)

3) *The Department shall request consent for release from a patient, a physician or hospital only upon a showing by the applicant for such release that obtaining the identities of certain patients, physicians or hospitals is necessary for his bona fide research directly related to the objectives of the* Head and Spinal Cord Injury Act. (Section 3 of the Head and Spinal Cord Injury Act)

i) Availability of Registry Information

1) All requests by medical or epidemiologic researchers for confidential registry data must be submitted in writing to the registry. The request must include a study protocol that contains: objectives of the research; rationale for the research, including scientific literature justifying current proposal; overall study methods, including copies of forms, questionnaires, and consent forms used to contact facilities, physicians or study subjects, including methods for documenting compliance with 42 CFR 2A, para. 1 a-i; 2 a-b; 3 a-b; 4 a-b; 5 a-b; 6 a-b; 7 a-b; 8 methods for the processing of data; storage and security measures taken to ensure confidentiality of patient identifying information; time frame of the study; a description of the funding source of the study (e.g., federal contract); the curriculum vitae of the principal investigator; and a list of collaborators. In addition, the research request must specify what patient or facility identifying information is needed and how the information will be used.

2) All requests to conduct research and modifications to approved research proposals involving the use of data that includes patient or facility identifying information shall be subject to a review to determine compliance with the following conditions:

A) The request for patient or facility identifying information contains stated goals or objectives;

B) The request documents the feasibility of the study design in achieving the stated goals and objectives;

C) The request documents the need for the requested data to achieve the stated goals and objectives;

D) The requested data can be provided within the time frame set forth in the request;

E) The request documents that the researcher has qualifications relevant to the type of research being conducted;

F) The research will not duplicate other research already underway using the same registry data when both require the contact of a patient, reporting facility or physician about an individual patient involved in the previously approved concurrent research; and

G) Other such conditions relevant to the need for the patient or facility identifying information and the patient's confidentiality rights, because the Department will only release the patient, physician in accordance with the provisions of this Section, or facility identifying information that is necessary for the research.

3) Research Agreements

A) The Department will enter into research contracts for all approved research requests. These contracts shall specify exactly what information is being released and how it can be used in accordance with the standards in subsection (c) of this Section. In addition, the researcher shall include an

assurance that:

i) Use of data is restricted to the specifications of the protocol;

ii) Any and all data that may lead to the identity of any patient, research subject, physician, other person, or hospital is strictly privileged and confidential and that such data will be kept strictly confidential at all times;

iii) All officers, agents and employees will keep all such data strictly confidential; will communicate the requirements of this subsection to all officers, agents, and employees; will discipline all persons who may violate the requirements of this Section; and will notify the Department in writing within 48 hours after any violation of this subsection, including full details of the violation and corrective actions to be taken;

iv) All data provided by the Department pursuant to the contract may only be used for the purposes named in the contract and that any other or additional use of the data may result in immediate termination of the contract by the Department; and

v) All data provided by the Department pursuant to the contract is the sole property of the Department and may not be copied or reproduced in any form or manner and that all data and all copies and reproduction of the data will be returned to the Department upon termination of the contract.

B) Any departures from the approved protocol must be submitted in writing and approved by the Director in accordance with subsection (c)(2) of this Section prior to initiation. No patient or facility identifying information may be released by a researcher to a third party.

4) The Department shall disclose individual patient or facility information to the reporting facility, which originally supplied that information to the Department, upon written request of the facility.

j) The patient identifying information submitted to the Department by those entities required to submit information under the Act and this Part is to be used in the course of medical study under Part 21 of Article 8 of the Code of Civil Procedure (735 ILCS 5). Therefore, this information is privileged from disclosure by Part 21 of Article 8 of the Code of Civil Procedure.

k) The identity of any facility, or any group of facts that tends to lead to the identity, of any person whose condition or treatment is submitted to the Department shall not be open to public inspection or dissemination. Such information shall not be available for disclosure, inspection or copying under the Freedom of Information Act or the State Records Act. All information for specific research purposes may be released in accordance with procedures established by the Department in this Section.

l) Every hospital shall provide representatives of the Department with access to information from all medical, pathological, and other pertinent records and logs related to reportable registry information. The mode of access and the time during which this access will be provided shall be by mutual agreement between the hospital and the Department. The Department shall not require hospitals to provide information on cases that are dated more than two years before the Department's request for further information.

m) Every hospital shall provide access to information regarding specified patients or other patients specified for research studies, related to reportable registry information, conducted by the Department. Any disputes as to access shall be resolved by the hospital and the Department within 30 days after requests for access have been denied.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2060 Trauma Patient Evaluation and Transfer

a) Patients who are determined in the pre-hospital setting to have sustained hypotension or are victims of cavity penetration of the neck or torso or any other trauma patient as deemed by medical control shall be classified as trauma patients in the field. The trauma surgeon response time begins at the time of field classification. The patient shall be immediately evaluated upon arrival at the ED.

b) Patients who are not classified in the field must be evaluated within 10 minutes of arrival at the trauma center. This evaluation shall be conducted by the attending ED physician or designee. "Designee", for the purposes of this Section, refers to ED staff including a surgeon acting as the ED attending, resident PGY four or greater, physician assistant, or registered nurse. By the time the 10 minute evaluation period has elapsed, the patient must be determined to be a Category I trauma patient (Section 515.Appendices C and F of this Part) or Category II (Section 515.Appendix C) or not to have met either Category I or II criteria. A patient cannot be downgraded by the ED physician once a category has been assigned. Upgrade to a Category I or II may occur at any time the patient's condition warrants. The trauma or specialty surgical response time begins at the time of upgrade.

c) EMS Regions or trauma centers may develop triage criteria that expand Category I and II criteria but may not delete any of the minimal criteria in Section 515.Appendix C of this Part.

d) The response period for trauma or specialty surgery for Category I or II patients is as specified in Section 515.2030(c), Section 515.2040(c) and Section 515.Appendix F of this Part.

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e) Trauma patients being transferred to a Level I or Level II facility or to more specialized care must be enroute within two hours of arrival when stabilized within the capabilities of the referring institution.

f) The Revised Trauma Score, as specified by the American Trauma Society, shall be used in all trauma centers. The Revised Trauma Score is determined by using the following criteria:

		Value	Points
1)	Respiratory Rate	10-29/Min	4
		less than 29/Min	3
		6-9/Min	2
		1-5/Min	1
		0	0
2)	Systolic Blood Pressure	greater than 89	4
		76-89	3
		50-57	2
		1-49	1
		0	0

3) Glasgow Coma Scale

A) Eye Opening Response	Points
Spontaneous	4
To Voice	3
To Pain	2
None	1

B) Best Verbal Response	
Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Sounds	2
None	1

C) Best Motor Response	
Obeys Commands	6
Localizes (Pain)	5
Withdraw (Pain)	4
Flexion (Pain)	3
Extension (Pain)	2
None	1

Total GCS	Revised Trauma Points
13-15	= 4
9-12	= 3
6-8	= 2
4-5	= 1
3	= 0

4) Revised Trauma Score = Total Points 1 + 2 + 3

g) Each EMS Region may include other criteria in addition to the Revised Trauma Score in defining a trauma patient and specifying where trauma patients should be transported according to the severity of the injury.

h) The components of Section 515.Appendix D of this Part shall be included in the trauma center policy.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2070 Trauma Center Designation to Local Health Departments

a) *The Department may delegate authority to local health departments in jurisdictions which include a substantial number of trauma centers. The delegated authority* includes, but is not limited to, *the authority to designate trauma centers with final approval by the Department, maintain a regional database with concomitant reporting of trauma registry data, and monitor, inspect and investigate trauma centers within their jurisdiction, in accordance with the requirements of* the Act and this Part. (Section 3.90(b)(11) of the Act)

b) *The department shall monitor the performance of local health departments with authority delegated* by the Act *based upon* the following *performance criteria:* (Section 3.90(b)(11)(A) of the Act) The local health department shall:

1) Enforce the Act and this Part, consistent with the authority delegated under Section 3.90(b)(11)(A) of the Act.

2) Designate trauma centers consistent with the provisions of the Act and this Part.

3) Upon notification of a Trauma Center's failure to submit Trauma Registry data to the Department in accordance with Section 515.2050 of this Part take steps to enforce this requirement within 10 working days.

4) Submit a Quarterly Report to the Department specifying all activities conducted under the delegated authority in accordance with the requirements of the Act and this Part.

5) Submit to the Department copies of all complaints within two working days of receipt and copies of all final investigation reports within 10 working days of the completion of the investigation.

6) Submit to the Department copies of quarterly trauma center focused outcome analyses required by Section 515.2030 of this Part.

c) *Delegated authority may be revoked for substantial non-compliance* with subsection (b) of this Section. *Notice of an intent to revoke shall*

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be served upon the local health Department by certified mail, stating the reasons for revocation and offering an opportunity for an administrative hearing to contest the proposed revocation. The request for a hearing must be received by the department within 10 working days of the local health department's receipt of notification. (Section 3.30(b)(11)(B) of the Act)

d) The director of a local health department may relinquish its delegated authority upon 60 days written notification to the Director of Public Health. (Section 3.30(b)(11)(C) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2080 Trauma Center Confidentiality and Immunity

a) All information contained in or relating to any medical audit performed by a trauma center of a trauma center's trauma services pursuant to the Act or by an EMS Medical Director, or his/her designee, of medical care rendered by system personnel shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure, as amended. Disclosure of such information to the Department pursuant to the Act and this Part shall not be considered a violation of Article VIII, Part 21 of the Code of Civil Procedure. (Section 3.110(a) of the Act)

b) Hospitals, trauma centers and individuals that perform or participate in medical audits pursuant to the Act shall be immune from civil liability to the same extent as provided in Section 10.2 of The Hospital Licensing Act. (Section 3.110(b) of the Act)

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2090 Trauma Center Fund

a) The Department shall distribute 97.5% of 50% of the moneys deposited into the trauma center fund, a special fund in the State Treasury, to Illinois hospitals that are currently designated as trauma centers. No monies may be distributed to a trauma center located outside of the State. The distribution to individual hospitals shall be based on the number of trauma cases, including cases where the hospital provides initial trauma care only, and the average length of stay for trauma cases at each hospital, according to data for the most recently completed state fiscal year. Section 3.225(a) and (b)(3) of the Act)

b) The moneys in the fund shall be allocated proportionally to each EMS Region so that the EMS Region receives the moneys collected from within its region for violations of laws or ordinances regulating the movement of traffic. (Section 3.225(b)(2) of the Act)

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1) The total amount of funds per EMS Region will be based on the moneys received from the counties in that Region.
   A) If a county has more than one EMS Region, the monies received from that county shall be divided among the Regions based on each Region's share of the county's trauma cases.
   B) EMS Regions that have developed joint EMS Region Plans to enable them to function as one Region shall be treated as one Region in the calculation.
2) At the beginning of each State fiscal year, the Department shall calculate a per trauma case allocation for each region, which shall be used to determine each trauma center's share of the funds collected during the previous State fiscal year.

c) To determine the percent of the Trauma Fund to be received by each hospital, divide the Hospital Distribution Factor for each trauma center by the Region Distribution Factor.
1) To determine the Region Distribution Factor, add all of the Hospital Distribution Factors for the trauma centers in the Region.
2) To determine the Hospital Distribution Factor, add the hospital's total admission score to the total case value score for the initial trauma care patients treated at the hospital.
   A) To determine the hospital's Total Admission Score, multiply the total case value score for admissions by the average length of stay.
      i) To determine the total case value score for admissions, assign case values for each patient (One patient may have more than one value, i.e., a person who has an ICU stay after an OR procedure.) admitted to the hospital according to the following:

Admission	2
Intensive Care Unit Stay	2
Operating Room Procedure	2
Mechanical Ventilation	3
Discharged to a rehabilitation facility	1

      The sum of all of the values is the total case value score for the patients admitted to the hospital.
      ii) To determine the average length of stay, divide the total length of stay for all patients admitted to the hospital by the total number of patients admitted to the hospital.
   B) To determine the total case value score for the initial trauma care patients, assign the case values for each initial trauma care patient treated by the hospital according to the following:

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Assigned status and nad length of stay > 12 hours from time of arrival in ED	2
Dead on arrival	0
Dying in emergency (DIE) with a trauma surgeon evaluation (TSE)	1.25
DIE without a TSE	.25
Against medical advice (AMA) with a TSE	1.25
AMA without TSE	.25
Transfer with TSE	1.25
Transfer without TSE	.25

The sum of all of the values is the total case value score for the initial trauma care patients treated by the hospital.

d) The Department will distribute funds from the Trauma Center Fund within 30 days after July 1 of each year.

(Source: Added at 20 Ill. Reg. _____, effective _____)

Section 515.2100 Pediatric Care

a) Upon the availability of federal funds for development of an emergency medical services for children program, the Department shall appoint an Advisory Board to advise the Department on all matters concerning emergency medical service for children and to develop and implement a plan to address identified pediatric areas of need. The Advisory Board shall assist in the formulation of policy to effect the purposes of the Act and this Part. The Advisory Board shall consist of 25 members to be appointed by the Director for a term of three years. Membership of the Advisory Board shall include:

1) One practicing pediatrician, one pediatric critical care physician, one board certified pediatric emergency physician, neonatologist, and one pediatric rehabilitation physician, to be recommended by the Illinois Chapter of the American Academy of Pediatrics;

2) One pediatric surgeon, to be recommended by the Illinois Chapter of the American College of Surgeons;

3) Two emergency physicians, one to be recommended by the Illinois Chapter of the American College of Emergency Physicians and one to be recommended by the National Association of EMS Physicians;

4) One family practice physician, to be recommended by the Illinois Chapter of the American Academy of Family Physicians;

5) Two registered nurses, one to be appointed upon recommendation of the Illinois Nurses Association and one to be appointed upon

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recommendation of the Illinois Chapter of the Emergency Nurses Association;

6) Two emergency medical technicians of differing levels, to be appointed, one each, upon recommendation of the Illinois EMT Association and Illinois Fire Fighters Association;

7) An EMS Coordinator recommended by the Northern Illinois and Southern Illinois EMS Coordinators Association;

8) A representative from each of the following agencies: Division of Specialized Care for Children; Illinois State Police; Illinois Fire Chiefs Association; Illinois Medical Society; SAFEKIDS Coalition; Illinois Hospital Association; Metropolitan Chicago Healthcare Council; Illinois Department of Children and Family Services; Illinois Kiwanis Association; health policy representative; and a child advocate group;

9) A non-voting member from the Division of Emergency Medical Services and Highway Safety and the Division of Family Health. EMS regional representation shall be through board members who serve as representative of other designated constituencies. Such members shall have dual representation status in advising the Illinois Department of Public Health, but shall retain one vote. The Department shall take into consideration regional representation when making advisory board appointments.

10) The Advisory Board members with medical backgrounds shall have expertise and interest in emergency or critical care medical services for children. Vacancies on the Advisory Council shall be filled for the unexpired term by appointment of the Director in the same manner as originally filled. The members of the Advisory Board shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties, including travel expenses. A majority of the members of the Advisory Board shall constitute a quorum for the conduct of business of the advisory committee. A majority vote of the members present at a meeting at which a quorum is established shall be necessary to validate any action of the committee.

b) The Department with the advice of the Advisory Board shall address and establish through the EMSC program at least the following:

1) Initial and continuing education programs for emergency medical services personnel which shall include training in the emergency care of infants and children;

2) Guidelines for referring children to the appropriate emergency or critical care medical facilities;

3) Guidelines for pre-hospital, hospital and other pediatric emergency or critical care medical service equipment;

4) Guidelines and protocols for pre-hospital and hospital facilities encompassing all levels of pediatric emergency medical services, hospital and pediatric critical care services, including, but not limited to, triage, stabilization, treatment, transfers and

referrals;

5) Guidelines for hospital-based emergency departments appropriate for pediatric care to assess, stabilize, and treat critically ill infants and children and if necessary to prepare the child for transfer to pediatric intensive care unit or pediatric trauma center;

6) Guidelines for pediatric intensive care units, pediatric trauma centers and intermediate care units fully equipped and staffed by appropriately trained critical care pediatric physicians, surgeons, nurses and therapists;

7) An inter-facility transfer system for critically ill or injured children;

8) Guidelines for pediatric rehabilitation units to ensure staffing by rehabilitation specialists and capabilities to provide any service required to assure maximum recovery from the physical, emotional and cognitive effects of critical illness and severe trauma;

9) Guidelines for the implementation of public education and injury prevention programs throughout the State in conjunction with local fire, public safety and school personnel;

10) Guidelines for the collection, analysis and dissemination of pediatric quality improvement information regarding ongoing improvements in the EMSC program; and

11) Guidelines and protocols for pre-hospital providers and hospital facilities for the treatment, documentation reporting, professional interactions with family members; and for referrals to social, psychological and rehabilitation services in suspected cases of child maltreatment.

(Source: Added at 20 Ill. Reg. _____, effective _____)

SUBPART I: EMS ASSISTANCE FUND

Section 515.3000 EMS Assistance Fund Administration

a) *EMT licensure examination fees collected shall be distributed by the Department to the Resource Hospital of the EMS System in which the EMT candidate was educated, to be used for educational and related expenses incurred by the System's hospitals, as identified in the EMS System Program Plan.* Section 3.220(b) of the Act)

b) *All other moneys within the EMS Assistance Fund shall be distributed by the Department to the EMS Regions for disbursement in accordance with protocols established in the EMS Region Plans, for the purposes of organization, development and improvement of Emergency Medical Services Systems, including but not limited to training of personnel and acquisition, modification and maintenance of necessary supplies, equipment and vehicles.* (Section 3.220(c) of the Act)

c) Award of Funds

1) Any Illinois licensed/designated EMS participant that provides EMS service within the State of Illinois may apply for funds through the Regional EMS Advisory Committee.

A) Application shall be made on forms prescribed and provided by the Department.

B) Applicants shall provide evidence of financial planning, to include but not be limited to: equipment replacement plans, budgeting plans, and fundraising plans.

2) Programs, services and equipment funded by the EMS Assistance Fund shall comply with the Act, this Part and the EMS Regional Plan in which the applicant participates.

3) The award of funds shall be based upon demonstrated need and one or more of the following:

A) Establishment of a new EMS agency, program or service where needed to improve emergency medical services available in an area;

B) Expansion or improvement of an existing EMS agency, program or service;

C) Replacement of equipment that is unserviceable or procurement of new equipment; and

D) Establishment, expansion or improvement of EMS education and training programs including the adult and pediatric population.

4) Deadlines for submission of applications shall be March 1 of each year. Applications must be received in the Division of Emergency Medical Services and Highway Safety by 5:00 pm on the date of the deadline. If the deadline falls on a Saturday, Sunday or State holiday, the application must be received by 5:00 pm the next business day.

5) Grants shall be awarded by July 1 of each year.

6) All recipients shall be asked to enter into a grant agreement as prescribed by the Department.

d) Emergency Awards

1) The Regional EMS Advisory Committee may recommend that the Department issue emergency awards. Emergency awards shall not exceed 10 percent of the total funds available in a year.

2) Applications shall be made in accordance with subsection (c) (1) and (2) of this section.

3) The award of funds shall be based on the demonstrated needs arising from a natural or man-made disaster.

e) Amount of Award

1) The amount of the award shall be based on the amount requested by the applicant, the recommendation of the Regional EMS Advisory Committee and the amount available in the Fund for distribution. The amount awarded shall not exceed the amount requested by the applicant.

2) It shall be the responsibility of the applicant to provide

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adequate information to substantiate the requested amount or any hardship claim.

g) Reporting Requirements
The grantee shall submit a report to the Division of Emergency Medical Services and Highway Safety every six months detailing the status of the grant funds. Within 60 days after the final disbursement of the grant funds, a final report shall be submitted to the Division. The final report shall consist of a financial report for the project and a brief narrative describing the completed project.

h) Modification of a Grant Agreement
1) Any change in the use of grant funds from that specified in the approved application shall be permitted only by modification of the grant agreement. The grantee may request the modification of the grant agreement by writing the Chief of the Division of Emergency Medical Services and Highway Safety detailing the reasons and circumstances necessitating the request.
2) The award may be suspended and all disbursements of funds held. There shall exist reasonable cause for suspension, such as:
A) Failure to comply with the Act and this Part;
B) Failure to follow the EMS Regional plan in which the grantee participates; and
C) Violation of the terms of the grant agreement.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.APPENDIX A A Request for Designation (RFD) Trauma Center

a) Name of hospital and address (typed)

_____

_____

_____

_____

1) Specify the designation level for which your hospital is applying:
A) Level I _____
B) Level II _____
2) The above named facility certifies that each requirement listed in this Request for Designation is met and will be operational by the date of designation.

_____
Typed name CEO/Administrator

_____
Signature CEO/Administrator Date

_____
Typed name Trauma Director

_____
Signature Trauma Director Date

_____
Contact person and phone

b) Level I Designation Criteria
Provide a Trauma Plan which explains how each of the requirements will be met. Options include provision of services in-house; by transfer agreement or by waiver. Requests for waiver must include *the requirement or standards which it considers compliance to be a hardship* and demonstrate how *there will be no reduction in the standards of medical care.* Section 3.185 of the Act) The Trauma Plan must be submitted in the order listed in this Appendix A. Each section of the Plan must reference the applicable portion of this Part by subsection number.
1) Table of Organization
Construct a Table of Organization to show the administrative relationships among all departments in the hospital, especially

as they relate to the trauma service. In addition, please include a separate table that shows the structure of the trauma service. The table must include but is not limited to:

A) Board of Directors
B) Chief Executive Officer
C) Department of Surgery
D) Trauma Service
E) Department of Medicine
F) Department of Radiology
G) Emergency Department
H) Rehabilitation Department

2) Trauma Director Requirements
   A) Job Description (Section 515.2030(n))
   B) Curriculum Vitae (Section 515.2030(b))
3) Surgical Services
   A) Description of the Trauma Service (Section 515.2030(c))
   B) Complete Attachment 1 to describe the trauma surgeon staffing and availability.
   C) If general surgery residents are used to fulfill the trauma surgeon requirement, provide a statement regarding the level of training; independent operating room privileges; supervision and oversight.
   D) Provide a statement regarding the ability to meet the requirements for surgical services in Section 515.2030(d)(1)-10) and e). Each surgical service must have a separate statement.
4) Non-surgical services and professional staff
   A) Emergency Department Director - provide board certification (Section 515.2030(g)(1))
   B) Emergency Physicians - complete Attachment 2 (Section 515.2030(f)(1)(A))
   C) Emergency Medicine Registered Nurse staffing (Section 515.2030(f)(1)(B) and Trauma Nurse Specialty requirements (Section 515.2030(j)(2)). Provide a statement that describes the staffing for each.
   D) Anesthesiology services - Provide a statement that describes the staffing (Section 515.2030(f)(2))
   E) Radiology staff - describe (Section 515.2030(f)(3))
   F) Intensive Care Medicine Unit - Describe bed availability (who has authority to move patients out to allow for admission of new patients; physician responsible for trauma patients; use of residents and nursing staffing (Section 515.2030(f)(4)).
      Provide a statement regarding the ability to meet the Intensive Care Unit equipment requirements.
   G) Laboratory - Provide a statement regarding the ability to meet the requirements (Section 515.2030(f)(5)).
   H) Other staffing and services - provide a statement regarding the ability to meet requirements (Section 515.2030(f)(6)-(11) and (j)(3) and (4)).
5) Equipment - provide a statement regarding the trauma center ability to provide and maintain the equipment listed in (Section 515.2030(h)(1)-(11)).
6) Helicopter landing - provide documentation to substantiate the requirements are being met (Section 515.2030(i)(1)-(4)).
7) Medical Audits - provide the trauma center plan to perform outcome analysis as described in Section 515.2030(j)(1)-(3).
8) Written protocols - Provide protocols as follows:
   A) Protocols and policies for treating patient (Section 515.2030(k)(1) and (3), (1))
   B) Minimum Trauma Field Triage Criteria (Section 515.Appendix C)
   C) In-house Triage policy (Section 515.Appendix F)
   D) Transferring patient to more specialized care (Section 515.2030(k)(2), Section 515.1060(e))
9) Trauma Flow Sheet - Provide a copy of the facility flow sheet (Section 515.2030(n))
10) Resource limitation policy that meets the requirements of Section 515.2030(q)(1) and (2)
11) Trauma Center Uniform Reporting Requirements (Section 515.2050 (a)-(d)). Provide a statement which includes:
   - the equipment available to meet the requirements
   - staff committed to support the registry reporting requirement
   - process used to identify reportable cases
   - commitment to meet reporting deadlines
   - software to be used for reporting

c) Level II Designation Criteria

Provide a Trauma Plan which explains how each of the requirements will be met. Options include provision of services in-house; by transfer agreement or by waiver. Requests for waiver must include *the requirement or standards which it considers compliance to be a hardship* and demonstrate how there *will* be no reduction *in* the *standards of medical care*. (Section 3.185 of the Act) Each section of the Trauma Plan must reference the applicable portion of this Part by section number.

1) Table of Organization

   Construct a Table of Organization to show the administrative relationships among all departments in the hospital, especially as they relate to the trauma service. In addition, please include a separate table that shows the structure of the trauma service. The table must include but is not limited to:

   A) Board of Directors
   B) Chief Executive Officer
   C) Department of Surgery
   D) Trauma Service

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E) Department of Medicine
F) Department of Radiology
G) Emergency Department

2) Trauma Director Requirements
A) Job Description (Section 515.2040(c))
B) Curriculum Vitae (Section 515.2040(b))

3) Surgical Services
A) Description of the Trauma Service (Section 515.2040(c))
B) Complete Attachment 1 to describe the trauma surgeon staffing and availability
C) If general surgery residents are used to fulfill the trauma surgeon requirement, provide a statement regarding the level of training; independent operating room privileges; supervision and oversight
D) Provide a statement regarding the ability to meet the requirements for surgical services in Section 515.2040(d)(1)-(4) and (e)(1)-(6). Each surgical service must have a separate statement

4) Non-surgical services and professional staff
A) Emergency Physicians - complete Attachment 2 (Section 515.2040(f)(1)(A))
B) Emergency Medicine Registered Nurse staffing (Section 515.2040(f)(1)(B)) and Trauma Nurse Specialty requirements (Section 515.2040(g)(2)). Provide a statement that describes the staffing for each
C) Anesthesiology services - Provide a statement that describes the staffing (Section 515.2040(f)(2))
D) Radiology staff - describe (Section 515.1040(f)(4))
E) Intensive Care Medicine Unit - Describe bed availability (who has authority to move patients out to allow for admission of new patients; physician responsible for trauma patients; use of residents and nursing staffing (Section 515.2040(f)(3)(A) and (B))
Provide a statement regarding the ability to meet the Intensive Care Unit equipment requirements (Section 515.2040(f)(3)(C))
F) Laboratory - Provide a statement regarding the ability to meet the requirements (Section 515.2040(f)(3)(A)-(G))
G) Other staffing and services - provide a statement regarding the ability to meet requirements (Section 515.2040(f)(5), (6), (7), (9), (10))

5) Equipment - provide a statement regarding the trauma center's ability to provide and maintain the equipment listed in Section 515.2040(n)(1)-(22)

6) Helicopter Landing - provide documentation to substantiate the requirements are being met (Section 515.2040(i)(1)-(4))

7) Medical Audits - Provide the trauma center plan to perform outcome analysis as described in Section 515.2040(j)(1)-(3)

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8) Written protocols - Provide protocols as follows:
A) Protocols and policies for treating patients (Section 515.2040(k)(1) and (3))
B) Minimum Trauma Field Triage Criteria (Section 515.Appendix C)
C) In-house Triage policy (Section 515.Appendix F)
D) Transferring patients to more specialized care (Section 515.2040(k)(2), Section 515.2060(e))

9) Trauma Flow Sheet - Provide a copy of the facility flow sheet (Section 515.2040(n))

10) Resource limitation policy that meets the requirements of Section 515.2040(g)(1)-(2)

11) Trauma Center Uniform Reporting Requirements (Section 515.2050(a)(d)) Provide a statement which includes:
- the equipment available to meet the requirements
- staff committed to support the registry reporting requirement
- process used to identify reportable cases
- commitment to meet reporting deadlines
- software to be used for reporting

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.APPENDIX B A Request for Renewal of Trauma Center Designation

a) Name of hospital, and address

_____

_____

_____

_____

b) Designation renewal level for which your hospital is applying:
1) Level I _____
2) Level II _____
Any change in designation level requires that the appropriate Request for Designation (RFD) Trauma Center Designation be completed.

c) The above named facility certifies that each requirement listed in this Request for Renewal of Trauma Center Designation is met.

_____
Signature CEO/Administrator Date

_____
Signature Trauma Director Date

_____
Contact person and phone number

d) Provide updated copies of all documents submitted for the most recent designation application or renewal request as outlined in Section 515.Appendix A for Level I or for Level II, items 1-11. This will constitute an updated Trauma Plan. The plan must be submitted in the order listed. Each item in the Trauma Plan must reference the applicable portion of this Part by subsection number.

e) Provide copies of minutes, on site or upon request, from any committees that are involved in focused outcome analysis for the most recently completed three months. *All information contained in or relating to any medical audit performed of a Trauma Center's trauma services...shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21, of the Code of Civil Procedure.* Section 3.110 of the Act)

f) Medical records may be requested to complete the renewal request.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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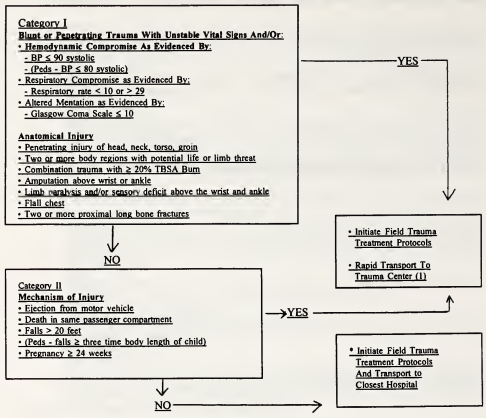
Section 515.APPENDIX C Minimum Trauma Field Triage Criteria

Section 515.APPENDIX C Minimum Trauma Field Triage Criteria*



* MANDATORY NOTIFICATION FROM FIELD OF TRAUMA SURGEON: SUSTAINED HYPOTENSION - BP ≤ 90 SYSTOLIC (PEDS ≤ 80 SYSTOLIC) ON TWO CONSECUTIVE MEASUREMENTS FIVE MINUTES APART

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CAVITY PENETRATION OF TORSO OR NECK

(1) > 25 minutes from Trauma Center, transport to nearest affiliate trauma hospital.
> 30 minutes from Trauma Center or affiliate trauma hospital, transport to nearest hospital.
> 45 minutes from Trauma Center or affiliate trauma hospital in a rural area where there is no comprehensive hospital available, transport to the nearest hospital.

+ Adapted from Trauma Care System Guidelines, ACEP, 1992, and Resources for Optimal Care of the Injured Patient, ACS, 1993. It is expected that each Region will expand upon this minimal triage set based on individual assessments, resources, and outcomes.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.APPENDIX D Standing Medical Orders

1. STANDING MEDICAL ORDERS/CARDIAC PROTOCOLS shall include at a minimum:

Routine Cardiac Care
Cardiac Arrest
Cardiogenic Shock
Ventricular Fibrillation
Ventricular Tachycardia
Ventricular Ectopy
EMD/PEA
PVST
Rhythm "Blocks"
Bradycardia
Asystole
Right Heart Failure

2. STANDING MEDICAL ORDERS/TRAUMA PROTOCOLS shall include at a minimum:

Field Triage Protocols
Shock (Hypovolemia)
Spinal Cord
Head Trauma
Load and Go Situations
Traumatic Arrest
Amputated Parts
Burns

3. STANDING MEDICAL ORDERS/PROTOCOLS FOR MEDICAL EMERGENCIES shall include at a minimum:

Asthma
Anaphylactic Shock
Diabetic Emergencies
Drug Overdose
Alcohol Related Emergencies
Coma, Origin Unknown
Status Epilepticus
Seizures
Heat Emergencies
Cold Emergencies
Poisoning

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Radiation Injuries
Renal Protocols (care of patients with shunts and fistulas)
Near Drowning

4. STANDARD MEDICAL ORDERS/OBSTETRIC/GYNECOLOGICAL PROTOCOLS shall include at a minimum:

Normal Deliveries
Hemorrhage, including third trimester bleeding
Abnormal Deliveries (i.e., cord or breech presentation)
Resuscitation of the Newborn
Rape Sexual Assault

5. STANDING MEDICAL ORDERS/PEDIATRIC PROTOCOLS shall include at a minimum:

PEDIATRIC PRIMARY ASSESSMENT - A foundation for all pediatric patient interactions, this protocol should reinforce the need for consistent, methodical patient assessment. Commonly referred to as "routine medical care" in adult protocols, the protocol should reinforce the following:

- Importance of rapid BLS interventions (i.e., CPR) specifically airway support
- Age appropriate signs and symptoms of pediatric respiratory distress
- Age appropriate airway interventions including the use of "blow-by" oxygen administration
- Indicators of adequate ventilation and perfusion
- Age appropriate immobilation of the pediatric trauma patient
- Recognition of and monitoring for imminent life threats
- Unique assessment considerations and emergent care requirements of children with special health care needs (CSHN), including those who are technologically dependent. Emphasize the appropriate inclusion of parents/primary caregivers

TREATMENT AND RECOGNITION OF THE FOLLOWING DYSRHYTHMIA:

- Asystole
- Pulseless Electrical Activity
- Ventricular Fibrillation or Pulseless Ventricular Tachycardia

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- Ventricular Tachycardia

Treatment modalities/algorithms should be consistent with the guidelines set forth by the American Heart Association's "Pediatric Advanced Life Support" algorithms. The use of intraosseous access should be taught to all ALS providers.

NEONATAL RESUSCITATION - Must incorporate the specific heart rate parameters and requisite interventions according to the American Heart Association recommendations.

PEDIATRIC RESPIRATORY ARREST - Treatment must be in accordance with the American Heart Association "Pediatric Advanced Life Support" guidelines.

PEDIATRIC RESPIRATORY DISTRESS - Differentiation should be made between "upper airway obstruction" (i.e., croup, epiglottitis and foreign body) and other "non-obstructive" causes of respiratory insufficiency (i.e., asthma, bronchiolitis, pneumonia). The potential for invasive airway interventions must also be identified.

PEDIATRIC BRADYCARDIA - Treatment in accordance with the American Heart Association recommendations.

PEDIATRIC TACHYCARDIA - Interventions for both wide and narrow complex tachycardias in accordance with the American Heart Association recommendations.

PEDIATRIC SHOCK - Differentiation should be made between "hypovolemic" (dehydration, hemorrhagic) and "distributive" (sepsis).

PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS - Special attention to the differentiation between symptomatic (hives), mild respiratory distress and severe respiratory distress.

PEDIATRIC SEIZURE - Must include the identification of rapid blood glucose monitoring in the field, considerations for febrile seizures and administration of rectal benzodiazepines (specifically in children less than 3 years old).

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS - Emphasize the importance of recognizing etiology, aggressive airway maintenance, glucose monitoring and naloxone administration.

PEDIATRIC TOXIC EXPOSURES/INGESTIONS - Incorporate accidental/environmental events commonly encountered in the pediatric population. Specific treatment interventions should be considered for the following:

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- Organophosphate poisoning
- Tricyclic antidepressant overdose
- Opiate overdose

Special consideration should be made to the susceptibility of children to environmental events such as:

- Hyperthermia
- Electrical injuries

PEDIATRIC HYPOTHERMIA - Emphasize the pediatric population at high risk for hypothermia: neonates and infants. Address aggressive airway management, warming techniques and recognition of frostbite injury. Interventions for arrhythmias in accordance with the American Heart Association recommendations.

PEDIATRIC NEAR DROWNING - Emphasize aggressive airway management and the potential for associated cervical spine injury and hypothermia.

PEDIATRIC BURNS - Special emphasis on the pediatric "rule of nines" for burn size estimation, aggressive airway management and triage to the appropriate facility. Differentiation should be made between thermal and chemical injuries.

PEDIATRIC TRAUMA - Emphasis should be made on mechanism of injury, limited on-scene time, aggressive airway maintenance and field triage to the appropriate facility.

SUSPECTED CHILD ABUSE/NEGLECT - Special emphasis should be made on careful documentation of physical findings, discrepancy between history of injury and physical findings, interaction between child and parent/caregiver, and characteristics of the environment. Discuss the pre-hospital provider's responsibility as a mandated reporter, and to report suspicions to the emergency room staff. Include directions for responding to parent/caregiver refusal to allow transport.

6. STANDING MEDICAL ORDERS/PROTOCOLS FOR SPECIAL SITUATIONS shall include at a minimum:

Psychological Emergencies
Sudden Infant Death Syndrome (SIDS)
Spousal Abuse
Geriatric Abuse
Child Abuse

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7. STANDING MEDICAL ORDERS/PROTOCOLS FOR THE PROCEDURES LISTED as well as any others which may be System specific:

Adult Intubation Procedure
Pediatric Intubation Procedure
Defibrillation
Transtracheal Ventilation-Cricothyrotomy
Chest Decompression
Cardioversion
Medication Administration-IV/ett

8. Standing medical orders may be organized as assessment based versus diagnostic, such as, altered mental status, abnormal vital signs, dysrhythmias and/or blocks, respiratory distress, chest pain.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.APPENDIX E Minimum Prescribed Data Elements

General information including but not limited to: agency and unit number, county, crash number (when available), date of call and incident location and type, destination location, type of medical control, resource hospital, crew member identification number, incident number, patient zip code.

Response time information including: time call received, time dispatched, time enroute, arrival time at location, patient contact time, departure time from location, arrival time at destination.

Documentation of who, other than the crew, renders assistance at the scene and the nature of the assistance.

Patient assessment including but not limited to: initial vital signs (systolic, diastolic, pulse, respirations), skin condition, Glasgow Coma Scale, past medical history, current illness/symptom (chief and secondary), injury site and type, injury criteria, pupils and where the patient was sitting in the vehicle.

Patient information including but not limited to: gender, date of birth, possible contributing factors to the injury/illness (i.e., motor vehicle, alcohol, equipment, HAZMAT, sports, etc.), protection used by the patient (i.e., seat belt, helmet, etc.), approximate pediatric weight.

Patient treatment including but not limited to: actual treatment rendered, medications administered, IV type, rate, site and attempts, EKG, body substance isolation, and CPR information (arrest witnessed, defibrulation, etc.), intubations and number of attempted intubations.

(Source: Added at 20 Ill. Reg. _____, effective _____)

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Section 515.APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

a) Patient Evaluation

1) Any EMS transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center. Mandatory field notification of a trauma surgeon will occur in cases of:

A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 80 Hg for a pediatric patient on two consecutive measures five minutes apart); or

B) Cavity penetration of the torso or neck.

2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED's attending emergency physician or designee immediately upon arrival. (Section 515.2060(a))

3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether or not they should be classified as a trauma patient within 10 minutes of arrival. (Section 515.2060(b))

4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.

5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.

6) Once the patient has been assigned a Category I or II status that patient cannot be downgraded until the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) Category I

The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of

identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician's discretion.

Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist, except for neurosurgery, within 60 minutes Level II and 30 minutes Level I from the notification that his or her services are needed at the hospital or initiation of specialty center transfer within 30 minutes of arrival and transfer completed within 2 hours. On those occasions wherein the need for operative intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes from the identification of need for operative intervention. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

c) Category II

Any other patient who is admitted for traumatic injury requires notification consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours of emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level I) of identified need by the emergency department physician except for neurosurgical injury which requires an on-site consultation within 60 minutes from notification that his or her services are needed at the hospital or initiation of specialty transfer within 30 minutes of arrival and transfer completed within 2 hours. On those occasions wherein the need for operative intervention has been identified the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes from the identification of need for operative intervention. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515.Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515.Appendix C).

(Source: Added at 20 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Emergency Medical Services Code

2) Code Citation: 77 Ill. Adm. Code 535

3)

Section Numbers:	Proposed Action:
535.10	Repealer
535.20	Repealer
535.50	Repealer
535.60	Repealer
535.100	Repealer
535.110	Repealer
535.120	Repealer
535.130	Repealer
535.140	Repealer
535.150	Repealer
535.160	Repealer
535.200	Repealer
535.210	Repealer
535.215	Repealer
535.216	Repealer
535.217	Repealer
535.220	Repealer
535.230	Repealer
535.240	Repealer
535.250	Repealer
535.260	Repealer
535.265	Repealer
535.270	Repealer
535.300	Repealer
535.310	Repealer
535.315	Repealer
535.320	Repealer
535.330	Repealer
535.335	Repealer
535.340	Repealer
535.350	Repealer
535.400	Repealer
535.410	Repealer
535.415	Repealer
535.420	Repealer
535.430	Repealer
535.432	Repealer
535.435	Repealer
535.440	Repealer
535.450	Repealer
535.500	Repealer
535.510	Repealer
535.515	Repealer

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535.520	Repealer
535.530	Repealer
535.532	Repealer
535.535	Repealer
535.540	Repealer
535.550	Repealer
535.600	Repealer
535.650	Repealer
535.700	Repealer
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535.952	Repealer
535.953	Repealer
535.1000	Repealer

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act, as amended by P.A. 89-177, effective July 19, 1995 [210 ILCS 50]

5) A Complete Description of the Subjects and Issues Involved: These rules implemented the Emergency Medical Services (EMS) Systems Act as it existed prior to the enactment of Public Act 89-177 (effective July 19, 1995). Public Act 89-177 repealed substantial portions of the Act and established new provisions in place of those repealed. New rules are needed to implement the revised Act. The Department plans to adopt replacement rules in conjunction with this Repealer. The rule will be included in 77

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Ill. Adm. Code 515 (Emergency Medical Services Code).

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect? No

7) Does this Rulemaking Contain an Automatic Repeal Date? No

8) Does this Rulemaking Contain Any Incorporations By Reference? No

9) Are there any other Proposed Amendments Pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State Mandate.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking: Interested persons may present their comments concerning these rules by writing within 45 days after this issue of the *Illinois Register* to:

Ms. Gail M. DeVito
Division of Governmental Affairs
Illinois Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
(217)782-6187

These rules may have an impact on small businesses. Any small business commenting on these rules shall indicate their status as such, in writing, in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of Small Businesses, Small Municipalities and Not-for-Profit Corporations Affected: Ambulance companies

B) Reporting, Bookkeeping or Other Procedures Required for Compliance: None

C) Types of Professional Skills Necessary for Compliance: None

13) Regulatory agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Repealer begins on the next page:

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NOTICE OF PROPOSED REPEALER

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 535
EMERGENCY MEDICAL SERVICES CODE (REPEALED)

SUBPART A: GENERAL

Section
535.10 Definitions
535.20 Incorporated Materials

SUBPART B: COMMUNICATIONS

Section
535.50 General Communications
535.60 EMS Systems Communications

SUBPART C: LICENSURE OF AMBULANCE SERVICE PROVIDERS

Section
535.100 Licensure of Ambulance Service Providers- General
535.110 Denial, Nonrenewal, Suspension and Revocation of Ambulance Service Provider License
535.120 Renewal of License
535.130 Renewal of License Denied
535.140 Revocation of License
535.150 Ambulance Licensing Requirements
535.160 Transfer of Care

SUBPART D: EMERGENCY MEDICAL SERVICES SYSTEM PROGRAM

Section
535.200 Emergency Medical Services System Program - General
535.210 EMS System Program Plan
535.215 Approval of Additional Drugs and Equipment
535.216 Automated Defibrillation
535.217 Do Not Resuscitate (DNR) Policy
535.220 Additions to an Approved Program (Repealed)
535.230 EMS System Personnel Standards
535.240 Minimum Standards for Continuing Operation
535.250 Resolution of Conflicts (Repealed)
535.260 System Participation Suspensions
535.265 System Review Board
535.270 State EMS Disciplinary Review Board

SUBPART E: EMERGENCY MEDICAL TECHNICIAN - BASIC

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(EMT-B)

Section
535.300 Emergency Medical Technician - Basic Training - General
535.310 EMT-B Testing
535.315 Fee For Testing
535.320 EMT-B Licensure
535.330 EMT-B Relicensure
535.335 EMT-B Continuing Education
535.340 Failure to Renew - Denial of Relicensure
535.350 Penalty (Repealed)

SUBPART F: EMERGENCY MEDICAL TECHNICIAN - INTERMEDIATE (EMT-I)

Section
535.400 Emergency Medical Technician - Intermediate Training - General
535.410 EMT-I Testing
535.415 Fee For Testing
535.420 EMT-I Licensure
535.430 EMT-I Relicensure
535.432 EMT-I Continuing Education
535.435 Failure to Renew - Denial of Relicensure
535.440 EMT-I Inactive Status
535.450 Penalty (Repealed)

SUBPART G: EMERGENCY MEDICAL TECHNICIAN - PARAMEDIC (EMT-P)

Section
535.500 Emergency Medical Technician - Paramedic Training - General
535.510 EMT-P Testing
535.515 Fee For Testing
535.520 EMT-P Licensure
535.530 EMT-P Relicensure
535.532 EMT-P Continuing Education
535.535 Failure to Renew - Denial of Relicensure
535.540 EMT-P Inactive Status
535.550 Penalty (Repealed)

SUBPART H: RECIPROCITY

Section
535.600 Reciprocity

SUBPART I: SUSPENSION, REVOCATION AND DENIAL OF LICENSURE OF EMTs

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Section
535.650 Suspension, Revocation and Denial of Licensure of EMTs

SUBPART J: DATA COLLECTION AND EVALUATION

Section
535.700 Data Collection and Evaluation

SUBPART K: WAIVER PROVISIONS

Section
535.750 Waiver Provisions

SUBPART L: REGISTERED PROFESSIONAL NURSE (FIELD RN/MICN)

Section
535.800 General Provisions
535.810 Field RN Training
535.820 Field RN Testing
535.830 Field RN Approval
535.840 Field RN Renewal
535.850 MICN Training
535.860 MICN Approval
535.870 Reciprocity

SUBPART M: CERTIFICATION OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section
535.900 Certification of (SEMSV) Programs - General
535.910 Denial, Nonrenewal, Suspension or Revocation of Certification
535.920 SEMSV Program Certification Requirements for All Vehicles
535.930 Helicopter and Fixed-Wing Aircraft Requirements
535.931 EMS Pilot Specifications
535.932 Aeromedical Crew Member Training Requirements
535.933 Aircraft Vehicle Specifications and Operations
535.934 Aircraft Medical Equipment and Drugs
535.935 Vehicle Maintenance
535.936 Aircraft Communications and Dispatch Center
535.940 Watercraft Requirements
535.941 Watercraft Vehicle Specifications and Operation
535.942 Watercraft Medical Equipment and Drugs
535.943 Watercraft Communications and Dispatch Center
535.950 Off-Road SEMSV Requirements
535.951 Off-Road Vehicle Specifications and Operation
535.952 Off-Road Medical Equipment and Drugs
535.953 Off-Road Communications and Dispatch Center

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SUBPART N: ADMINISTRATIVE WARNINGS AND FINES

Section
535.1000 Administrative Warnings and Fines

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Adopted at 5 Ill. Reg. 5670, effective May 19, 1981; amended and codified at 8 Ill. Reg. 11623, effective June 27, 1984; amended at 11 Ill. Reg. 1433, effective February 1, 1987; amended at 11 Ill. Reg. 17219, effective October 15, 1987; amended at 11 Ill. Reg. 20945, effective December 15, 1987; amended at 12 Ill. Reg. 22406, effective December 15, 1988; amended at 13 Ill. Reg. 15414, effective September 15, 1989; amended at 13 Ill. Reg. 15716, effective September 15, 1989; amended at 14 Ill. Reg. 15390, effective September 1, 1990; amended at 15 Ill. Reg. 5722, effective April 10, 1991; amended at 15 Ill. Reg. 18167, effective December 16, 1991; amended at 17 Ill. Reg. 8196, effective May 21, 1993; amended at 18 Ill. Reg. 14375, effective September 10, 1994; amended at 19 Ill. Reg. 13299, effective September 15, 1995; repealed at 20 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

Section 535.10 Definitions

For the purposes of this Part:

"Act" means the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

"Administrative Hearing" means a hearing conducted by the Department pursuant to a Department action to deny, suspend or revoke an EMT license or an ambulance license, and in conformance with the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100).

"Advanced Life Support-Mobile Intensive Care (ALS/MIC)" means an advanced level of pre-hospital and inter-hospital emergency care that includes basic life support functions, (including cardiopulmonary resuscitation (CPR) plus cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, administration of antiarrhythmic agents, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures) initiated for the treatment of real or potential acute life threatening conditions under the direction of a physician licensed to practice medicine in all of its branches or a Registered Professional Nurse/MICN or Registered

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Professional Nurse/Field RN, and where authorized by the Project Medical Director in an Illinois Department of Public Health approved advanced life support system. (Section 4.01 of the Act)

"Advanced Life Support-Mobile Intensive Care Services (ALS/MIC)" means a hospital providing with the approval of the Illinois Department of Public Health (See Subpart D of this Part), *pre-hospital emergency medical care through the use of advanced life support-mobile intensive care personnel, equipment and vehicles under the direction of a Project Medical Director.* (Section 4.02 of the Act)

"Advanced Life Support Personnel" means persons engaged in the provision of advanced life support, as defined and regulated by this Part. (Section 4.03 of the Act)

"Aeromedical crew member" or "Watercraft crew member" or "Off-road SEMSV crew member" means an individual, other than an EMS pilot, who has been approved by a SEMSV Medical Director for specific medical duties in a helicopter or fixed-wing aircraft, on a watercraft, or on an off-road SEMSV used in a Department-certified SEMSV Program. (See Sections 535.932(a) and (b), or 535.940(a)(8)(B) through (D), or 535.950(a)(7)(A) and (B) of this Part.)

"Alternate Project Medical Director" or "Alternate PMD" means the physician who is designated by the Resource Hospital to direct the ALS/ILS operations in the absence of the Project Medical Director.

"Ambulance" means any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated for the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless. (See Subpart C of this Part.) (Section 4.05 of the Act)

"Ambulance Service Provider" or "Ambulance Provider" means any individual, group of individuals, corporation, partnership, association, trust, joint venture, individual doing business under an assumed name, unit of local government or other public or private ownership entity which owns and operates a business or service utilizing one or more ambulances or EMS vehicles for the transportation of emergency patients.

"Areawide Hospital Emergency Medical Services (AHES) Committees" means those bodies formed pursuant to Section 1.1 of the Hospital Emergency Service Act [210 ILCS 80/1.1], and in compliance with the Hospital Licensing Requirements (77 Ill. Adm. Code 250.730).

"Associate Hospital" means a hospital participating in an approved EMS

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System in accordance with the EMS System Program Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting the mobile intensive care personnel training program nor the responsibility for the overall operation of the EMS System program. The Associate Hospital must have a basic or comprenensive Emergency Department with a 24-hour physician coverage. It must have a functioning Intensive Care Unit and/or a Cardiac Care Unit. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

"Associate Hospital EMS Coordinator" means the EMT-P or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the ALS or ILS System, in accordance with the Department-approved EMS System Program Plan.

"Associate Hospital EMS Medical Director" means the physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the ALS or ILS System, in accordance with the Department-approved EMS System Program Plan.

"Basic Life Support (BLS) Services" means the rendering of basic level of pre-hospital and inter-hospital emergency care, including but not limited to airway management, cardiopulmonary resuscitation, control of shock and bleeding and splincing of fractures, as outlined in a basic emergency care course approved by the Department and meeting the current national curriculum of the United States Department of Transportation. (Section 4.06 of the Act)

"Central Communications System" means a radio and communications command and control center or centers responsible for accepting calls from the public for emergency medical services, for dispatching emergency medical services personnel and vehicles, for radio coordination of emergency medical services vehicles and personnel, for coordination of medical communications between emergency medical services personnel and public safety agencies, and where applicable, for coordination and management of radio frequencies devoted to biomedical telemetry. (Section 4.07 of the Act)

"Channel, Half-Duplex" means a radio channel that transmits and receives signals, but in only one direction at a time.

"Consumer" means a person in this State who is a recipient or potential recipient of the services provided by an emergency medical services system, who receives no direct or indirect personal, financial, or professional benefit as a result of an association with health care or emergency services other than that generally shared by

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the public at large, and who is not otherwise considered a provider under the provisions of the Act. (Section 4.08 of the Act)

"Department" means the Department of Public Health, State of Illinois. (Section 4.09 of the Act)

"Director" means the Director of the Department of Public Health, State of Illinois. (Section 4.10 of the Act)

"Dysrhythmia" means a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and conduction.

"Effective Radiated Power (ERP)" means the power gain of a transmitting antenna multiplied by the net power accepted by the antenna from the connected transmitter.

"Electrocardiogram" means a single lead rhythm strip graphic recording of the electrical activity of the heart by a series of deflections which represent certain components of the cardiac cycle.

"Emergency" means a condition or situation in which an individual declares a need for immediate medical attention or when that need is declared by emergency medical personnel or a public safety official. (Section 4.11 of the Act)

"Emergency Medical Services (EMS) System or System" means an organization of providers which through a program plan submitted to and approved by the Department (pursuant to Subpart D of this Part) *entitles a hospital to utilize qualified personnel specified in the Act to provide or coordinate pre-hospital and inter-hospital emergency care at an advanced or intermediate level, to victims of illness or injury within the area specified in the program plan. Advanced or intermediate level services may include the utilization of BLS Level Services. One hospital in each program plan must be designated as the resource hospital. All hospitals and ambulance providers participating in an EMS System must specify their level of participation in the program plan.* (Section 4.18 of the Act)

"Emergency Medical Services System Survey" means a questionnaire which provides data to the Department for the purpose of compiling annual reports.

"Emergency Medical Services Vehicle (EMS vehicle)" means any vehicle used for BLS, ILS or ALS, as a special EMS unit or rescue vehicle, operating within an approved EMS System.

"Emergency Medical Technician-Ambulance" or "EMT-A" means a person who

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has successfully completed a course of instruction in basic life support services as required and is currently licensed by the Department in accordance with standards prescribed by the Act and this Part, *who provides emergency medical services.* (Section 4.12 of the Act)

"Emergency Medical Technician-Basic" or "EMT-B" means Emergency Medical Technician-Ambulance (EMT-A).

"Emergency Medical Technician Intermediate" or "EMT-I" means an EMT-A currently licensed by the Department who has completed a Department approved course of instruction (pursuant to Subpart F of this Part) *in specific advanced life support-mobile intensive care services and who is currently functioning in a program approved by the Department to provide such services under the supervision and control of a Project Medical Director. No sponsorship or employment shall be required for training or holding licensure as an EMT-I.* (Section 4.15 of the Act)

"Emergency Medical Technician-Paramedic" or "EMT-P" means a person who has successfully completed a Department approved course of instruction (pursuant to Subpart G of this Part) *in advanced life support-mobile intensive care services and is currently licensed by the Department. No sponsorship or employment shall be required for training or holding license as an EMT-P.* (Section 4.13 of the Act)

"EMS System Coordinator(s)" means the designated individual(s) responsible to the Project Medical Director and Project Director for coordination of the educational and functional aspects of the System program.

"EMS System Program Plan" means the document prepared by the Resource Hospital and approved by the Department which describes the EMS System program and directs the program's operation (see Subpart D of this Part).

"FCC" means the Federal Communications Commission.

"Fixed-wing aircraft" means an engine-driven aircraft that is heavier than air, and is supported in-flight by the dynamic reaction of the air against its wings.

"Health Systems Agency" means a health systems agency as defined in 42 USC 300 L-1 a). (Section 4.14 of the Act)

"Helicopter" or "Rotorcraft" means an aircraft that is capable of vertical take-offs and landings, including maintaining a hover.

"Hospital" has the meaning ascribed to it in the Hospital Licensing

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Act [210 ILCS 85]. (Section 4.04 of the Act)

"Instrument Flight Rules" or "IFR" means the operation of an aircraft in weather minimums below the minimums for flight under visual flight rules (VFR). (See General Operating and Flight Rules, 14 CFR 91.115 through 91.129.)

"Instrument Meteorological Conditions (IMC)" means meterological conditions expressed in terms of visibility, distance from clouds and ceiling which requires Instrument Flight Rules.

Intermediate Life Support Care" or "ILS" means an intermediate level of pre-hospital and inter-hospital emergency care that includes BLS Care, plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures initiated for the treatment of real or potential acute life-threatening conditions, under the direction of a physician licensed to practice medicine in all of its branches or a Registered Professional Nurse/MICN or Registered Professional Nurse/Field RN and where authorized by the Project Medical Director in a Department approved EMS System. (Section 4.19 of the Act)

"Intermediate Life Support Services" means a hospital providing, with the approval of the Department (See Subpart D of this Part), *pre-hospital and inter-hospital emergency medical care through the use of Intermediate Life Support mobile intensive care personnel, equipment and vehicles, under the direction of a Project Medical Director.* (Section 4.20 of the Act)

"Mobile Radio" means a two-way radio installed in an EMS vehicle which may not be readily removed.

"Off-Road Specialized Emergency Medical Services Vehicle" or "Off-Road SEMSV" or "Off-Road SEMS Vehicle" means a motorized cart, golf cart, ATV (all-terrain-vehicle), or amphibious vehicle which is not intended for use on public roads.

"Participating Hospital" means a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which may or may not have monitoring capabilities and which receives patients transported by System EMS vehicles under the direction of the Project Director or PMD designee. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

"Physician" means any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 60].

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"Pilot" or "EMS Pilot" means a pilot certified by the Federal Aviation Administration who has been approved by a SEMSV Medical Director to fly a helicopter or fixed-wing aircraft used in a Department-certified SEMSV Program. (See Section 535.931 of this Part.)

"Portable Radio" means a hand-held radio which accompanies the user during the conduct of emergency medical services.

"Pre-Hospital Care" means those emergency medical services rendered to emergency patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to hospitals. (Section 4.16 of the Act)

"Pre-Hospital Care Provider or System Participant" means any EMT-3, I, P, Ambulance, Ambulance Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, Field RN, MICN or Physician serving on an ambulance or giving voice orders over an EMS System and is subject to suspension by the Project Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

"Project Director" means the administrator, appointed by the Resource Hospital with the approval of the Project Medical Director, responsible for the administration of the EMS System.

"Project Medical Director" or "PMD" means the physician appointed by the Resource Hospital who has the responsibility and authority for total management of the EMS System. (See Sections 535.210(h) and 535.230(a) of this Part.)

"Registered Nurse" or "Registered Professional Nurse" or "RN" means a person who is licensed as a professional nurse under the Illinois Nursing Act of 1987 [225 ILCS 65].

"Registered Professional Nurse/Field RN" means a Registered Nurse, licensed under the Illinois Nursing Act of 1987, who has been approved by the Project Medical Director in a Department-approved EMS System, and who has satisfactorily completed additional supplementary training including but not limited to courses in extrication, telemetry and communications, advanced cardiac life support, including defibrillation and intubation or its equivalent, and either trauma nurse specialist or nurse trauma life support or their equivalents as approved by the Project Medical Director. (Section 4.21 of the Act)

"Registered Professional Nurse/MICN" or "Mobile Intensive Care Nurse" *means a Registered Nurse, licensed under the Illinois Nursing Act of 1987, who has satisfactorily completed the Mobile Intensive Care Nurse course, including training in telemetry and communication, advanced Cardiac Life Support, and a Pre-Hospital Trauma Support Course or its equivalent, as approved by the Department.* (Section 4.21(a) of the Act)

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"Resource Hospital" means the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. (See Subpart D of this Part.) The Resource Hospital, through the Project Medical Director, assumes responsibility for the entire program including the clinical aspects, operations and educational programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

"SEMSV Medical Control Point" or "Medical Control Point" means the communication center from which the SEMSV Medical Director or his or her designee issues medical instructions or advice to the aeromedical, watercraft, or off-road SEMSV crew members.

"SEMSV Medical Director" or "Medical Director" means the physician appointed by the SEMSV Program who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part. (See Section 535.320(e) of this Part.)

"SEMSV Program" or "Specialized Emergency Medical Services Vehicle Program" means a program operating within an EMS System, pursuant to a program plan submitted to and certified by the Department, utilizing specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

"Specialized Emergency Medical Services Vehicle" or *"SEMSV" means a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads.* (Section 4.30 of the Act) "Primarily intended", for the purposes of this definition, means one or more of the following:

Over 50 percent of the vehicle's operational (e.g. in-flight) hours are devoted to the emergency transportation of the sick or injured;

The vehicle is owned or leased by a hospital or ambulance provider and is utilized for the emergency transportation of the sick or injured;

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The vehicle is advertised as a vehicle for the emergency transportation of the sick or injured;

The vehicle is owned, registered or licensed in another state and is utilized on a regular basis to pick up and transport the sick or injured within or from within this State; or

The vehicle's structure or permanent fixtures have been specifically designed to accommodate the emergency transportation of the sick or injured.

"State Emergency Medical Services Disciplinary Review Board" means a five-member board appointed by the Governor to review and affirm, reverse or modify orders to suspend an EMT or other individual provider from participation within an EMS System. (Section 10.2 of the Act) (See Sections 535.265 and 535.270 of this Part.)

"System Participation Suspension" means the suspension from participation within an EMS System of an individual or individual provider, as specifically ordered by that System's Project Medical Director.

"System Review Board" or "Board" means a panel of individuals assembled within an EMS System for the purpose of reviewing a decision by the Project Medical Director to suspend from participation an EMT or other individual provider participating within that System. The Board shall consist of four voting members and a chairperson who shall vote only in the event of a tie. The Project Medical Director shall appoint as two standing members of the Board, the System Project Director or designee and an emergency room physician from within the System who is not the Project Medical Director. The remaining two voting members and chairperson shall be selected by the provider from a list provided by the Project Medical Director. That list shall consist of the names of six providers from within the System who are in the same provider category and level. If the provider is in a category or level which consists of fewer than six other providers, he or she may choose the two voting members and chairperson from any of the System's provider lists.

"Telecommunications Equipment" means a radio capable of transmitting and/or receiving voice and electrocardiogram (EKG) signals.

"Telemetry" means the transmission of data by wire, radio, or other means from remote sources to a receiving station for recording and analysis.

"Unit Identifier" is a number assigned by the Department for each EMS vehicle in the State to be used in radio communications.

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"Watercraft" means a nautical vessel, boat, airboat, hovercraft or other vehicle that operates in, on or across water.

"911" means an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services including police, fire, medical ambulance and rescue.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.20 Incorporated Materials

a) The following federal regulations and standards are incorporated in this Part:
   1) United States General Services Administration, Federal Specification for Ambulance, KKK-A-1822C (1985), which may be obtained from General Services Administration, Specifications Section, Room 6654, 7th and D Streets, S.W., Washington, D.C. 20407. (See Section 535.150.).
   2) United States Department of Transportation, Emergency Medical Technician - Basic: National Standard Curriculum (1994), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (See Sections 535.215(a); 535.300(c) and (h); 535.310(a); 535.335(b); 535.400(c) and (h); 535.410(a); 535.420(a) and (b); 535.500(c) and (e); 535.510(a) and (d); and 535.530(d).)
   3) United States Department of Transportation, Emergency Medical Technician - Intermediate: National Standard Curriculum (1985), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (See Sections 535.215(a); 535.216; 535.400(c) and (d); 535.410(a); 535.420(a) and (b); 535.430(b); and 535.432(b).)
   4) United States Department of Transportation, Emergency Medical Technician - Paramedic: National Standard Curriculum (1985), which may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (See Sections 535.215(a); 535.500(c) and (e); 535.510(a) and (d); 535.530(c); 535.532(b); 535.810(b) and (c); and 535.850(a) and (b).)
   5) 47 CFR 90 (1990) (Section 535.60(a)).
   6) Air Taxi Operations and Commercial Operators (14 CFR 135, (1990), Subparts A, Sections 135.1 through 135.43, B, Sections 135.61 through 135.125, C, Sections 135.141 through 135.185, D, Sections 135.201 through 135.229, E, Sections 135.241 through 135.247, F, Sections 135.261, J, Sections 135.411 through 135.443).
b) All incorporations by reference of federal regulations and the standards of nationally recognized organizations refer to the regulations and standards on the date specified and do not include any additions or deletions subsequent to the date specified.
c) The following statutes and State regulations are referenced in this

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Part:
1) Federal Statutes:
U.S. Code 42, The Public Health and Welfare, 42 USC 300 L-1(a) (1991). (See Section 535.100.)
2) State of Illinois statutes:
A) Hospital Emergency Services Act [210 ILCS 80]. (See Section 535.10.)
B) Hospital Licensing Act [210 ILCS 85]. (See Section 535.10.)
C) Medical Practice Act of 1987 [225 ILCS 60]. (See Section 535.10.)
D) The Illinois Nursing Act of 1987 [225 ILCS 65]. (See Section 535.10.)
E) Code of Civil Procedure [735 ILCS 5]. (See Section 535.700(g).)
3) State of Illinois regulations:
A) Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100). (See Sections 535.140(d) and 535.250(g).)
B) Hospital Licensing Requirements (77 Ill. Adm. Code 250). (See Sections 535.10, 535.200(d) and 535.210(e).)

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

SUBPART B: COMMUNICATIONS

Section 535.50 General Communications

a) All existing VHF radios used by ambulance services for basic life support services shall:
1) Have two-way ambulance-to-hospital communication capability.
2) Utilize unit identifier numbers or other descriptive means of identification locally acceptable.
b) All new VHF radios used after the effective date of this Part by ambulance services for basic, intermediate or advanced life support services shall:
1) Have two-way ambulance-to-hospital communications capability on frequencies assigned by the Department.
2) Utilize channel and tones assigned by the Department.
3) Utilize unit identifier numbers or other descriptive means of identification locally acceptable.
c) All radio communications systems pertaining to BLS will require preliminary coordination with and recommendations from the Department communications personnel.
d) All pre-hospital care providers must provide information relative to the mechanism used to access and dispatch emergency vehicles within their respective service area.
e) All hospitals participating in an EMS Plan or receiving emergency patients by ambulances must:

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1) Have two-way ambulance-to-hospital communications capability on a frequency determined and assigned by the Department, and
2) Have two-way hospital-to-hospital communications capability.

(Source: Amended at 11 Ill. Reg. 20945, effective December 11, 1987)

Section 535.60 EMS Systems Communications

All EMS Systems shall comply with the following requirements:
a) The System's communications plan shall be submitted for approval to the Department's EMS Communications staff, and shall include the following in accordance with 47 CFR 90 (1988):
1) A listing of access numbers of Emergency Medical Services including a description of plans to utilize or to implement a "911" System or CMED if or when available and a list of agencies involved;
2) A description of the EMS vehicle dispatch system to be utilized;
3) A description of communications interface with existing Systems;
4) A description of plans to handle hospital-to-hospital communications;
5) A complete and detailed communications equipment description;
6) A general description of UHF or cellular telephone and back-up radio capabilities, such as VHF or UHF radio,including Resource and Associate Hospital interconnections and control functions if any exist;
7) A general description of paramedic input telephones including Resource and Asssociation Hospital interconnections if any exist;
8) A general description of EMS vehicle dispatch communication including areas covered, mutual aid agreements, radio and telephone capabilities including radio channels used (i.e., 155.220MHz) and present and future 911 involvement;
9) All mobile and portable communications equipment to be used by EMS System personnel;
10) A detailed block diagram sketch or sketches showing all transmitters, receivers, antennas, control consoles, ECG demodulators, patient monitor equipment, recorders, telephones, couplers, with signal flow lines;
11) Radio equipment specifications, including effective radiated power, antenna height, ground heights, antenna pattern, antenna direction, channels used, continuous tone-controlled squelch system tones, digital dial numbers;
12) Modes of operation such as half-duplex and multiplex;
13) Radio coverage maps showing locations of all transmitting and receiving equipment and control points;
14) A general discussion concerning radio interference and steps taken to minimize it (i.e., the use of only short ECG transmission, thus allowing several EMS units to use one channel, minimizing ERP and antenna height);

15) Copies of FCC licenses or application, and
16) A narrative description of the System's plans for informing the community of the EMS System program development, how citizens can gain access, and the ongoing operation of the System.

b) EMS telecommunications equipment shall be configured to allow the Project Medical Director, or designee, to monitor all vehicle to hospital transmissions and hospital to vehicle transmissions within the System.

c) Resource and Associate Hospitals shall have an operational control point for a MERCI VHF/UHF base station, telemetry receiving and monitoring and any Associate to Resource intercom lines.

d) Physician direction shall be provided from the operational control point of an approved Resource or Associate Hospital (See Subpart D).

e) Telecommunications equipment necessary to fulfill the requirements of this Part shall be staffed and maintained 24-hours every day, including VHF and UHF base stations and their required telephone equipment.

f) EMS System personnel shall be capable of properly operating their respective communications equipment.

g) All telecommunications equipment shall be maintained to minimize breakdowns. Procedures shall be established to provide immediate action to be taken by operating personnel to ensure rapid restoration in case breakdowns do occur.

h) Written protocols shall describe communications procedures for operation of the System, all base station control points, and field units. These protocols shall contain provisions for limiting the time of individual radio transmissions to include only necessary information transfer (i.e., short telemetry strips). Mobile base control points and mobile units shall have an easily accessible copy of the protocols pertaining to their stations.

i) The Department shall approve channel assignments, effective radiated power, antenna height and locations, and tones in new Systems to insure radio coverage in approved program service area without causing interference in existing Systems.

j) In existing Systems, the Department shall monitor and may require modifications in channel assignments, tones, antenna height and locations, and ERP to correct documented radio interference problems.

(Source: Amended at 15 Ill. Reg. 5722, effective April 10, 1991)

SUBPART C: LICENSURE OF AMBULANCE SERVICE PROVIDERS

Section 535.100 Licensure of Ambulance Service Providers - General

a) No person, either as owner, agent, or otherwise shall furnish, operate, conduct, maintain, advertise, or otherwise be engaged in the provision of an ambulance vehicle in the State without a current ambulance service provider license issued pursuant to Subpart C of

this Part by the Department, provided that the ambulance is not owned, operated, licensed or regulated by a unit of local government.

b) An initial application for license shall be filed with the Department on a form prescribed, prepared and furnished by the Department. The application shall contain such information as, but not limited to, applicant name and address, and identification as to make, model, year, and vehicle identification number, and state vehicle license number, for each vehicle to be covered by the license.

c) Each license shall be for a period of one year and shall expire one year from the date of issuance.

d) The Department shall issue an annual license, if requirements of the Act and this Part are met, as determined by the results of an inspection conducted by the Department pursuant to this Subpart.

e) Each license shall be issued to the person named in the application for the vehicles identified in the application. The license shall not be assigned to any other person. The Department shall also issue a separate license certificate for each vehicle, which shall be posted in the vehicle at all times. Additional vehicles may be included within the license only after inspection by the Department pursuant to this Subpart. The licensee shall notify the Department, in writing, within ten (10) days if a vehicle covered by the license is permanently removed from service. Such notice shall include returning the license certificate for that vehicle.

f) The Department shall have the right to make inspections and investigations as are necessary in order to determine the status of compliance with the provisions of the Act and this Part. Pursuant to any inspection or investigation, a licensee shall allow the Department access to all records, equipment and vehicles relating to activities required by the Act and this Part.

g) Each vehicle covered by an ambulance service provider license shall be approved by the Department to operate at a specific level of service (BLS, ILS or ALS). In order to change the level of service for a specific vehicle:
1) The licensee shall submit a written request to the Project Medical Director;
2) The Project Medical Director shall submit a copy of that request to the Department, along with written verification that the licensee meets the equipment and staffing requirements of this Part and the EMS System Plan for the requested level of service;
3) The Department shall then amend the provider license and vehicle certificate to reflect the new level of service.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.110 Denial, Nonrenewal, Suspension and Revocation of Ambulance Service Provider License

a) The Director, after providing notice and an opportunity for an

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administrative hearing to the applicant or licensee, shall deny, suspend, revoke or refuse to renew an ambulance service provider license in any case in which it is found that the applicant, licensee or vehicles fail to comply with the requirements of the Act or this Part.

b) If the failure to comply relates only to one or more specific vehicles operated by the applicant or licensee, and the applicant or licensee has one or more vehicles which are in compliance, the Director's action shall be limited to those vehicles which fail to comply with the Act or this Part.

c) If the failure to comply concerns all of the provider's vehicles or the provider's operation as a whole, the Director's action shall cover the entire ambulance service provider license.

d) If the Director finds that the failure to comply can be corrected or remedied within an identified period of time determined necessary to correct the failure prior to the expiration of the license, the Director shall suspend, rather than revoke, the license or portion thereof. If the failure cannot be corrected or remedied within an identified period of time prior to the expiration of the license, or if the provider has a documented history of non-compliance then the Director shall revoke the license or portion thereof.

e) In the event that an immediate and serious danger to the public's health, safety or welfare exists, the Director shall order an emergency suspension of an ambulance service provider's license or portion thereof. Subsequent to the emergency suspension order, the Director shall promptly initiate proceedings to revoke or suspend the license or portion thereof and provide the licensee with an opportunity for an administrative hearing. The emergency suspension shall remain in effect throughout the course of such proceedings, unless the Director lifts the suspension order after determining that the emergency situation has been corrected or remedied. In determining whether to lift the suspension the Director will consider whether or not patient care is compromised.

f) All administrative hearings conducted pursuant to this Section shall be governed by the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100).

(Source: Amended at 14 Ill. Reg. 15390, effective September 1, 1990)

Section 535.120 Renewal of License

An application for renewal of license shall be filed with the Department on a form prescribed, prepared and furnished by the Department at least sixty (60) days prior, but not sooner than ninety (90) days before the expiration date of the currently held license.

(Source: Amended at 14 Ill. Reg. 15390, effective September 1, 1990)

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Section 535.130 Renewal of License Denied

An application for renewal of license may be denied for any of the following reasons:

a) A violation of any provision of the Act or of this Part.

b) Any ground upon which an application for a license may be denied as set forth in Section 535.110.

Section 535.140 Revocation of License

A license may be revoked for any of the following reasons:

a) A violation of any provision of the Act or of this Part.

b) Any ground upon which an application for a license may be denied as set forth in Section 535.110.

c) In the event that an immediate and serious danger to the public health, safety and welfare exists, the Director may order an emergency suspension of a license. Emergency suspension may be ordered, but revocation proceedings shall thereafter be promptly instituted.

d) Before denying an application or refusing to renew a license or revoking an existing license, the Department shall be governed by the Illinois Administrative Procedure Act. All hearings shall be governed by the Department's Rules of Practice and Procedures for Administrative Hearings (77 Ill. Adm. Code 100).

Section 535.150 Ambulance Licensing Requirements

a) Vehicle Design

1) Each vehicle used as an ambulance after the effective date of this Part shall comply with the criteria established by the U.S. General Services Administration's Specification for Ambulance (KKK-A-1822C), with the exception of the following Sections: 1.2.1 Ambulance Type - "Star of Life"; 3.8.2 Ambulance Emergency Lighting; 3.16.2 Color, paint, and finish; 3.16.4 Emblems and Markings; and 3.22 as determined by the Department by an inspection.

2) Each vehicle that does not meet the U.S. General Services Administration's Ambulance Design Standards (KKK-A-1822C) as determined by the Department by an inspection, but is operational on the effective date of this Part shall be considered to be in compliance with this Part until there is a transfer of ownership.

b) Equipment Requirements - Basic Life Support Vehicles
Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:

1) Stretchers, Cots & Litters

A) Primary Patient Litter

i) Wheeled

ii) At least 75" to 80" long and 22" wide

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iii) Allows for the head to be tilted upward to a 60 degree semi-sitting position
iv) Provided with a crash stable, quick release, 3 point fastener
v) Designed to insure the frame or handle will permit up to four persons to carry the litter
B) Secondary Patient Litter
Shall be folding and/or collapsible type
2) Oxygen
A) Installed
i) Is supplied by at least 3000 liters of oxygen and tank is secured in at least 3 positions so as to provide maximum safety for patients and personnel (M cylinder)
ii) Is equipped with a reducing valve (from 2000 PSI cylinder to 50 PSI) with pressure gauge
iii) Is equipped with yoke
iv) Has a pressure gauge flow meter that will deliver up to 15 liters per minute
v) Has delivery tubes
vi) Has oxygen outlet accessible to the technician at the head of the primary litter
vii) Has one each adult, child and infant sized oxygen masks that are semi-open, valveless, transparent and disposable
viii) Has 3 each nasal cannulas
B) Portable
i) Is of at least 300 liter capacity (D or E cylinder)
ii) Is equipped with yoke
iii) Has pressure gauge flow meter (not gravity-dependent) that will deliver up to 15 liters per minute
iv) Has delivery tube
v) Has one each adult, child and infant sized oxygen masks that are semi-open, valveless, transparent and disposable
vi) Has an additional full 300 liter capacity cylinder carried on the vehicle (D or E cylinder)
3) Suction
A) Installed
i) Is powerful enough to provide an airflow of over 20 liter/minute at the end of the delivery tube and a vacuum of over 300 mm Hg (11.811 inches) when the tube is clamped
ii) Has vacuum adjustable for use with children and intubated patients
iii) Has suction yoke, unbreakable collection bottle, water for rinsing, and suction tube accessible to the technician at the head of the primary litter

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iv) Has tube of sufficient length to reach the head of the primary and secondary litters
v) Is fitted with large-bore, non-kinking, translucent suction tubing
vi) Has 3 each sterile, single-use suction catheters with on/off control in small, medium and large sizes
vii) Has 3 each tonsil tip suction handles or catheters, single-use
viii) Can be disassembled for ease of cleaning and decontamination
B) Portable
i) Is powerful enough to provide an airflow of at least 12 liters per minute at the end of the suction tube, and a vacuum of at least 300 mm Hg (11.811 inches) to be reached within 12 seconds after tube is clamped
ii) Has 3 each tonsil tip suction handles or catheters, single-use
iii) Is fitted with large-bore, non-kinking, translucent suction tubing with sufficient length so that unit does not have to be placed on top of patient
iv) Has an unbreakable collection bottle capable of holding at least 500 ml
v) Has 3 each sterile, single-use suction catheters with on/off control in small, medium and large sizes
vi) Operates from an integral battery supply which is rechargeable or gas powered and will allow the unit to meet the air flow and suction requirements of this Section for at least 15 minutes. If the portable suction unit is powered by pressurized oxygen in a cylinder, it will be attached to its own oxygen cylinder and not to spare D or E cylinders intended for portable oxygen use
vii) A manually operated suction device is acceptable if approved by the Department.
4) Medical Equipment
A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask and child size bag-valve-mask ventilation unit with child and infant size transparent masks
B) Lower-extremity traction splint, adult size
C) Blood pressure cuff, 1 each, adult and pediatric, and gauge
D) 2 each stethoscopes
E) Pneumatic counterpressure trouser kit, adult size
F) Long spine board with 2 each torso straps, 9 feet in length, 1 each chin and head strap
G) Short spine board with 2 each torso straps, 9 feet in length, 1 each chin and head strap or vest type (wrap around) extrication device kit
H) Airway, oropharyngeal - adult, child and infant sizes

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I) Bandage shears, 1 each
J) Padded board splints, 2 each 15"x3" (or equivalent)
K) Padded board splint, 1 each 4'6"x3" (or equivalent) and padded board splint, 3'x3"
L) Rigid cervical collars - 1 each, small, medium and large sizes. Shall be made of rigid material to minimize flexation, extension and lateral rotation of the head and cervical spine when spine injury is suspected
M) Sand bags - 4 each, about 4 inches in width, 2 inches in thickness and 12 inches in length or lateral C-Spine and head immobilization device(s)
N) Patient restraints, arm and leg, sets
O) Hypothermic thermometer or electronic thermometer capable of aiding in the diagnosis of hypothermia - 1 each

5) Medical Supplies
A) Trauma dressing - 6 each
B) Sterile gauze pads - 20 each, 4 inches by 4 inches
C) Bandages, soft roller, self adhering-type, 10 each, 6 inches by 5 yards
D) Vaseline gauze - 2 each, 3 inches by 8 inches
E) Adhesive tape rolls - 2 each
F) Triangular bandages or slings - 5 each
G) Burn sheets - 2 each, sterile
H) Sterile solution (normal saline) - 4 each, 500 cc or 2 each, 1,000 cc plastic bags
I) Aluminum foil roll or Silver Swaddler - 1 each
J) Bite sticks - 2 each
K) Obstetrical kit, sterile - 1 each, pre-packaged with instruments
L) Syrup of Ipecac, 1 each
M) Cold packs, 3 each
N) Emesis basin - 1 each
O) Drinking water - 1 quart, in non-breakable container, Sterile water may be substituted
P) Disposable drinking cups - 5 each
Q) Ambulance emergency run reports - 10 each, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form, as follows:
i) For Basic Life Support vehicles, including, but not limited to, time of call and response times, date, location, type of call, site of injury, mechanism of injury, injury prevention devices, patient assessment, patient care provided at the Basic Life Support Level, method of transportation, radio communication, hospital destination, driver and EMT/Field RN identification numbers.
ii) For Intermediate Life Support vehicles, including, but not limited to, time of call and response times, date, location, type of call, site of injury, mechanism of injury, injury prevention devices, patient assessment, patient care provided at the Intermediate Life Support Level, method of transportation, radio communication, hospital destination, driver and EMT-Intermediate/Field RN identification numbers.
iii) For Advanced Life Support vehicles, including, but not limited to, time of call and response times, date, location, type of call, site of injury, mechanism of injury, injury prevention devices, patient assessment, patient care provided at the Advanced Life Support level, method of transportation, radio/telemetry communication, hospital destination, driver and EMT-Paramedic/Field RN identification numbers.
iv) An ambulance Emergency Run Report will be completed and a copy filed with the receiving Emergency Department prior to leaving the Receiving Hospital.
R) Pillows - 2 each, for ambulance cot
S) Pillowcases - 2 each, for ambulance cot
T) Sheets - 2 each, for ambulance cot
U) Blankets - 2 each, for ambulance cot
V) CPR mask - 1 each, with safety valve to prevent backflow of expired air and secretions
W) Hot packs - 3 each
X) Urinal - 1 each
Y) Bedpan - 1 each
Z) Remains bag - 1 each
AA) Non-porous disposable gloves
BB) Impermeable red or biohazard-labelled isolation bag
CC) Face protection through any combination of masks and/or eye protection and/or face shields

c) Equipment Requirements - Intermediate and Advanced Life Support Vehicles
Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsection (b) of this Section and shall also comply with the equipment and supply requirements as determined by the Project Medical Director in the System in which the ambulance and its crew participate.

d) Equipment Requirements - Rescue and/or Extrication
Each ambulance shall document the mechanism and agency that provides rescue services, and carry the following:
1) Wrecking bar, 24"
2) Goggles for eye safety
3) Fire extinguisher - 2 each, ABC dry chemical, minimum 5 pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment
4) Flashlight - 1 each, battery powered 6 volt, stand-up lantern

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e) Equipment Requirements - Communications Capability
Each ambulance must have ambulance to hospital radio communications capability and meet the requirements provided in Section 535.50 of this Part.

f) Personnel Requirements
1) Each ambulance shall be staffed by a minimum of two EMTs, Field RNs or physicians on all emergency calls.
2) Each Basic Life Support vehicle using automated defibrillation shall be staffed by a minimum of one EMT-B approved by the Project Medical Director for automated defibrillation, a Field RN or physician and one other EMT, Field RN or physician.
3) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one EMT-I, Field RN or physician and one other EMT, Field RN or physician. Each ILS vehicle using automated defibrillation shall be staffed by a minimum of one EMT-I approved by the Project Medical Director for automated defibrillation, a Field RN or physician and one other EMT, Field RN or physician. Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one EMT-P, Field RN or physician and one other EMT, Field RN or physician.
4) Each ambulance provider that operates an emergency transport vehicle shall ensure through written agreement with the EMS System that the agency providing emergency care at the scene and en route to a hospital meets the requirements of this Suppart.

g) Operational Requirements
1) Any operation of an ambulance while transporting a patient to a hospital shall be done in accordance with the requirements of the Act and this Part.
2) A licensee shall operate its ambulance in compliance with this Part, twenty-four hours a day, every day of the year. Except as required below, each individual vehicle within the ambulance service shall not be required to be operated twenty-four hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS or BLS level, and such coverage will meet the requirements of this Section.
A) At the time of application for initial or renewal licensure, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.
i) A current roster shall also be submitted which lists the EMTs, Field RNs and/or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, and daytime telephone number, and shall state whether such person is

generally scheduled to be on site or on call.
ii) An actual or proposed 4 week staffing schedule shall also be submitted, which covers all vehicles, includes staff names from the submitted roster and states whether each staff member is scheduled to be on site or on call during each work shift.
B) Licensees that are part of an EMS System shall be required to obtain the Project Medical Director's approval of their vehicles' hours of operation prior to submission to the Department. A Project Medical Director may require specific hours of operation for individual vehicles in order to assure appropriate coverage within the System.
C) A licensee that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in such advertisement the hours of operation for those vehicles, if individual vehicles are not available twenty-four hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate twenty-four hours a day.
3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record on the emergency run report the patient's blood pressure, pulse, respiration, skin condition, level of consciousness, chief complaint and any treatment rendered.
4) A licensee shall provide emergency service within the service area on a per need basis without regard to the patient's ability to pay for such service.
5) A licensee shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers.
6) A licensee shall operate its ambulance at a level not exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless such vehicle is operated pursuant to an EMS System-approved in-field service level upgrade. (See Section 535.210(i)(7) of this Part.)
7) *When a basic life support ambulance has been requested by telephone and the estimated response time is more than 8 minutes, the dispatcher shall advise the person making the request of the estimated time of arrival of the ambulance.* (Section 7.1 of the Act)

h) AGENCY NOTE: Any provider may request a waiver of any requirements in this Section under the provisions of Section 535.750. Examples of situations in which waivers of the requirement that ambulances carry pneumatic counter pressure trouser kits will be granted are as follows: When the Department is notified that a hospital or Project Medical Director will not order the use of a pneumatic counter pressure trouser kit or M.A.S.T. trousers by emergency medical

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personnel on a Basic Life Support Vehicle; and that a waiver is necessary to allow adequate time or progressive procurement of the pneumatic counter pressure trouser kits over a period of one to three years for those ambulance agencies that claim financial hardship.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.160 Transfer of Care

a) BLS ambulance personnel at the scene of an emergency shall allow any ILS or ALS ambulance personnel at the scene access to the patient, for the purpose of assessing whether ILS or ALS care is warranted, provided that doing so would not appear to jeopardize the patient's condition.

b) If the ILS or ALS personnel determine that the patient requires ILS or ALS care, the BLS personnel shall transfer care of that patient to the ILS or ALS personnel, provided that doing so would not appear to jeopardize the patient's condition.

(Source: Added at 18 Ill. Reg. 14375, effective September 10, 1994)

SUBPART D: EMERGENCY MEDICAL SERVICES SYSTEM PROGRAM

Section 535.200 Emergency Medical Services System Program - General

a) The provisions of this Subpart shall apply to all hospitals, ambulance providers and personnel participating in the delivery of Advanced Life Support/Mobile Intensive Care and/or Intermediate Life Support/Mobile Intensive Care to the sick and injured at the scene of an emergency, during transport to a hospital or during inter-hospital transport, and within a hospital emergency department until the responsibility for the care of the patient is assumed by the medical personnel at the receiving hospital.

b) The emergency care described in subsection (a) shall only be offered or rendered through an approved Emergency Medical Services (EMS) System. An EMS System shall not become operational nor shall any training of System personnel begin until a letter of approval has been issued by the Department.

c) An applicant for EMS System approval shall submit to the Department three copies of a written System Program Plan signed by the Project Medical Director which includes all of the information and documentation required by Section 535.210 of this Subpart.

d) An approved System which desires to modify its System Program Plan shall submit to the Department a written amendment signed by the Project Medical Director, along with a written statement of approval from its AHES Committee. A System shall not implement a modification to its approved Program Plan until a letter of approval has been issued by the Department.

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e) After receiving a Program Plan for a proposed EMS System or an amendment to an approved System Program Plan, the Department shall notify the applicant or System within thirty (30) days if its Program Plan or amendment is incomplete. Such notice shall include a description of the information or documentation needed to complete the Program Plan or amendment.

f) After receiving a complete Program Plan for a proposed EMS System or amendment to an approved System Program Plan, the Department shall issue a letter of approval or disapproval within 120 days. A letter of disapproval shall include the reasons for disapproval. The Department shall approve EMS Systems which meet the requirements of this Part and the Act.

g) The Department shall not review requests for equipment or training grants until a letter of approval has been issued by the Department.

h) The Department shall inspect, pursuant to a complaint filed with the Department or as it deems necessary to verify compliance with the Act and this Part, any equipment, records or vehicles used or maintained by a proposed or approved EMS System or by any provider participating in a proposed or approved EMS System. Routine inspections shall be conducted no more often than every three years.

i) Letters of commitment required in Section 535.210 shall be updated at least every three years.

j) A hospital is not required to join an AHES committee. However, if it has elected to do so, the hospital shall comply with its commitments as outlined in the plan administered by the AHES committee and shall be subject to the provisions of subsection (d) and Sections 535.210(e) and 535.220 of this Part.

k) For the purposes of this Part, changes in any of the following shall be considered modifications of a System Program Plan:

1) Resource Hospital, Associate Hospital or Participating Hospital,
2) Project Medical Director,
3) AHES participation,
4) System service area (See Section 535.210(f) of this Part),
5) Written standing orders (See Section 535.210(m)(1) of this Part),
6) Methods(s) of providing EMS services (See Section 535.210(i) of this Part),
7) Specific role(s) of Associates or Participating Hospital(s),
8) Additional ambulance providers, changes in level of service for System ambulance providers, or role(s) of specific ambulance providers (See Section 535.210(k)(2) of this Part),
9) Response areas of specific ambulance providers (See Section 535.210(k)(3) of this Part),
10) Access and dispatch procedures and mechanism (See Section 535.210(k)(14) of this Part),
11) Communications plan (See Sections 535.60(a)(1) through (14),(h) and (i), 535.210(m)(4)(B) and (C) of this Part),
12) Equipment and drug requirements (See Section 535.210(m)(2) of this Part),

13) System training, continuing education and examination requirements,
14) Quality Assurance policies (See Section 535.210(m)(5) of this Part),
15) Data collection and evaluation policies (See Section 535.210(m)(6) of this Part),
16) Override policies (See Section 535.210(m)(7)(B) of this Part),
17) Disciplinary/suspension policies or procedures (See Section 535.210(m)(9) of this Part),
18) The addition of drugs or equipment pursuant to Section 535.215 of this Part, and new written standing medical orders concerning those new drugs or equipment,
19) The addition of an Automatic Defibrillator Operation program pursuant to Section 535.216 of this Part.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.210 EMS System Program Plan

An Emergency Medical Services (EMS) System Program Plan shall contain the following information:

a) The name and address of the Resource Hospital;
b) The names and resumes of the following persons:
   1) The Project Medical Director,
   2) The Project Director,
   3) The EMS System Coordinator;
c) The names and addresses of each Associate or Participating Hospital;
d) The names and addresses of each ambulance provider participating within the EMS System;
e) A letter from the appropriate AHES committee which contains the following:
   1) A statement that the Resource Hospital meets the requirements of a basic or comprenensive emergency facility (See "Basic" and "Comprehensive" emergency services as defined in Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250));
   2) A brief description of the AHES area including categorization scheme, a specialty availability and critical care referral patterns; and
   3) A statement that the proposed EMS System Program Plan has been reviewed and approved.
f) A map of the EMS System's service area indicating the locations of all hospitals and ambulance providers participating in the System;
g) Letters of commitment from the following persons at the Resource Hospital, which describe the commitment of the writer and his or her office to the development and ongoing operation of the EMS System, and which state the writer's understanding of and commitment to any necessary changes such as emergency department staffing and educational requirements:

   1) The Chief Executive Officer of the hospital,
   2) The Chief of the Medical Staff, and
   3) The Director of the Nursing Services;
h) A letter of commitment from the Project Medical Director describing the PMD's agreement to:
   1) Be responsible for the ongoing education of all System personnel including coordinating didactic and clinical experience;
   2) Develop written standing orders (treatment protocols, standard operating procedures) to be used in the PMD's absence and certify that all involved personnel will be knowledgeable in emergency care and capable of providing treatment and using communications equipment once the program is operational;
   3) Provide the name and resume of the Alternate Project Medical Director;
   4) Be responsible for supervising all personnel participating within the System, as described in the System Program Plan;
   5) Develop or approve one or more ambulance emergency run reports (run sheets) covering all types of ambulance runs performed by System ambulance providers;
   6) Ensure that the Department has access to all records, equipment and vehicles under the authority of the PMD, during any Department inspection, investigation or site survey;
   7) Notify the Department of any changes in personnel providing pre-hospital care in accordance with the EMS System Program Plan approved by the Department;
   8) Be responsible for the total management of the System, including the enforcement of compliance with the System Program Plan by all participants within the System;
   9) Ensure that a copy of the application for renewal (a form supplied by the Department) is provided to every EMT-I or EMT-P within the System who has not been recommended for recertification by the Project Medical Director; and
   10) Be responsible for compliance with the provisions of Sections 535.260 and 535.265 of this Part;
i) A description of the method(s) of providing EMS services, which includes the protocols for:
   1) single vehicle response and transport;
   2) dual vehicle response;
   3) level of first response vehicle;
   4) level of transport vehicle;
   5) use of mutual aid agreements;
   6) informing the caller requesting an emergency vehicle of the estimated time of arrival when the vehicle response is estimated to be longer than six minutes; and
   7) In-Field Service Level Upgrades: An EMS System may establish protocols and procedures which allow ILS or ALS personnel to board a BLS vehicle in the field in order to render a higher level of prehospital emergency care. Such protocols shall, at a

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minimum, require the temporary transfer of the ILS or ALS equipment to the BLS vehicle. The higher-level personnel shall assume in-field responsibility for the patient during the remainder of the prehospital transport, and the vehicle will be recognized by the Department as approved for the higher level of service during the remainder of that patient transport;

j) A letter of commitment from each Associate or Participating Hospital within the System that includes the following:

1) Signed statements by the hospital's Chief Executive Officer, Chief of the Medical Staff and Director of the Nursing Service describing their commitments to the standards and procedures of the System;
2) A description of how the hospital will relate to the EMS System Resource Hospital, its involvement in the ongoing planning and development of the program, and its utilization of the education and continuing education aspects of the program;
3) A commitment to meet the System's educational standards for MICNs and Field RNs;
4) An agreement to provide exchange of all drugs and equipment with all pre-hospital providers participating in the System;
5) An agreement to utilize the standard treatment orders as established by the Resource Hospital;
6) An agreement to follow the operational policies and protocols of the System;
7) An agreement to participate in the training and continuing education of pre-hospital personnel;
8) An agreement to collect and provide relevant data as determined by the Resource Hospital;
9) A description of the hospital's data collection and reporting methods and the personnel responsible for maintaining all data;
10) The names and resumes of the Associate Hospital EMS Medical Director and Associate Hospital EMS Coordinator;
11) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey; and
12) If the nospital is a participant in another System, a description of how it will interact within both Systems and how it will ensure that communications interference as a result of this dual participation will be minimized;

k) A letter of commitment from each ambulance provider participating within the System that includes the following:

1) For each EMS vehicle participating within the System:
   A) The year, model, make, and vehicle identification number;
   B) The license plate number;
   C) The Department license number, unless exempt from Department licensure (See Section 9 of the Act);
   D) The base location address; and
   E) The level of service (advanced, intermediate or basic);

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2) A description of its role in providing advanced life support, intermediate life support, basic life support and patient transport services with the System;
3) Definitions of the primary, secondary and outlying areas of response for each EMS vehicle used within the System;
4) A map or maps indicating the base locations of each EMS vehicle, the primary, secondary and outlying areas of response for each EMS vehicle, the population base of each service area and the square mileage of each service area;
5) A commitment to optimum response times of 4-6 minutes in primary coverage areas, 10-15 minutes in secondary coverage areas, and 15-20 minutes in outlying coverage areas;
6) A commitment to 24-hour coverage;
7) A commitment that within one year after Department approval of the EMS System, each ambulance at the scene of an emergency and during transport of emergency patients to and between hospitals will be staffed in accordance with the requirements of Section 535.150(f)(1) and (2);
8) Copies of written mutual aid agreements with other providers and/or a description of the provider's own back-up system, which detail how adequate coverage will be ensured when an EMS vehicle is responding to a call and a simultaneous call is received for service within that vehicle's coverage area;
9) A statement that emergency services that an EMS vehicle is authorized to provide shall not be denied on the basis of the patient's inability to pay for such services;
10) An agreement to file an appropriate EMS run sheet or form for each emergency call, as required by the System;
11) An agreement to maintain the equipment required by Section 535.150 and by the System, in working order at all times, and to carry the medication as required by the System;
12) An agreement to notify the Project Medical Director of any changes in personnel providing pre-hospital care in the System in accordance with the policies in the System Manual;
13) A copy of its current FCC license(s);
14) A description of the mechanism and specific procedures used to access and dispatch the EMS vehicles within their respective service areas;
15) A list of all personnel providing pre-hospital care, their license numbers, expiration dates and levels of licensure (EMT-B, EMT-I, EMT-P), their Field RN or MD status;
16) An agreement to allow the Department access to all records, equipment and vehicles relating to the System during any Department inspection, investigation or site survey;
17) An agreement to allow the Project Medical Director or designee access to all records, equipment and vehicles relating to the System during any inspection or investigation by the PMD or designee to determine compliance with the System Program Plan;

18) Documentation that its communications capabilities meet the requirements of Section 535.50 of this Part;
19) Documentation that each EMS vehicle participating in the System complies with the vehicle design, equipment and extrication criteria as provided in Section 535.150(a)(1) and (b) of this Part; and
20) An agreement to follow the approved EMS policies and protocols of the System;

l) Descriptions and documentation of each communications requirement provided in Section 535.60 of this Part;

m) A System Manual, the format of which shall be System specific as to organization, which shall contain but not be limited to subsections (1) through (11) of this subsection (m); and which except for training program examinations and quizzes, student and instructor evaluations, and any examinations used to test or monitor System participants' proficiency, shall be available to all System participants. The entire Manual shall be available to any agency authorized to evaluate, survey or accredit the program.
1) The Project Medical Director's written standing orders (treatment protocols, Standard Operating Procedures) to be used in the PMD's absence, including the circumstances under which the MICN will call the PMD or a designated physician to the operational control point, and what the nurse's limitations are;
2) A list of all equipment and drugs required for EMS vehicles;
3) The System's program and requirements for the training and continuing education of EMTs, Field RNs and MICNs including but not limited to:
A) Curriculum (EMT training programs shall be taught in accordance with the United States Department of Transportation (DOT) Emergency Medical Technician National Standard Curriculum);
B) Teaching schedules;
C) Training program examinations, including the formats to be used (i.e., essay, multiple-choice, classroom or take-home quizzes, practical examinations);
D) Clinical experiences;
E) Training program entrance and successful completion requirements;
F) Training program student and instructor evaluations;
G) Clinical and didactic relicensure requirements, including a requirement that each EMT's continuing education records shall be kept on file at the Resource Hospital, and that copies shall be provided to the EMTs;
H) System examinations, if any, used to test and monitor an EMT's continued proficiency to render the level of care for which the EMT is licensed;
I) A System may require that up to one-half of the yearly didactic continuing education hours that are required toward

relicensure, as determined by the Department, be earned through attendance at System-taught courses;
J) Any didactic continuing education course that has received a State site code shall be accepted by the System, subject only to the requirements of subsection (m)(3)(I) of this Section;
4) Communications standards and protocols including:
A) The information contained in the System Program Plan relating to the requirements of Sections 535.60(a)(1), (2), (3) and (4), 535.60(b) and 535.60(g) of this Part;
B) Protocols ensuring that physician direction and voice orders to EMS vehicle personnel and other hospitals participating in the System are provided from the operational control point of the Resource or Associate Hospital; and
C) Protocols ensuring that voice orders via radio and using telemetry shall be given by or under the direction of the Project Medical Director or the PMD's designee, who shall be either an MICN, a Field RN or a physician;
5) Quality assurance measures for patient care, ambulance operation and System training activities, including but not limited to monitoring training activities to ensure that the instruction and materials are consistent with United States Department of Transportation training standards for EMTs and Section 4 and 13 of the Act, unannounced inspections of pre-hospital services, and internal provider self-assessments;
6) Data collection and evaluation methods that include:
A) The mechanism for collecting data from hospitals and pre-hospital providers;
B) A copy of the pre-hospital reporting form;
C) The method employed to evaluate data and to notify and correct patient care or reporting discrepancies; and
D) A sample of the information and data to be reported to the Department summarizing System activity;
7) Operational policies that delineate the respective roles and responsibilities of all providers in the System regarding the provision of emergency services, including:
A) Abuse of controlled substances by System personnel;
B) Resource Hospital overrides (situations in which Associate Hospital orders are overruled by the Resource Hospital);
C) Infectious disease and disinfection procedures;
D) Reporting and documentation of problems; and
E) Protocols for ILS/ALS System personnel to assess the condition of a patient being initially treated in the field by BLS personnel, for the purpose of determining whether a higher level of care is warranted and transfer of care of the patient to the ILS or ALS personnel is therefore appropriate. Such protocols shall include a requirement that neither the assessment nor the transfer of care can be

initiated if it would appear to jeopardize the patient's condition, and shall require that such activities of the System personnel be done under the immediate direction of the Project Medical Director or designee;

8) Medical-Legal policies addressing:
   A) A patient's right of refusal;
   B) Minor patient/guardian consent;
   C) Patient abandonment;
   D) Coroner policy;
   E) Emotionally disturbed patients;
   F) Do not resuscitate situations;
   G) Patient confidentiality/release of information;
   H) Interaction with law enforcement/evidence;
   I) Reporting of suspected crimes (i.e., child abuse);
   J) Physician on the scene; and
   K) Durable power of attorney for health care;

9) Any procedures regarding disciplinary/suspension decisions and the review of those decisions which the System has elected to follow in addition to those required by the Act;

10) The responsibilities of the EMS Coordinator(s), as designated by the Project Medical Director, including data evaluation, supervision of clinical, didactic and field experience training, and physician and nurse education as required; and

11) The responsibilities of the Project Director;

n) If the Resource Hospital for a proposed EMS System is currently participating in an existing System, the following additional information must be provided:

1) A clear description of its current role and status within the existing System;

2) Its rationale for separating from the existing System and developing its own program;

3) A description of the methods to be used for ensuring the coordination of emergency services with adjacent Systems, including the System that it proposes to leave;

4) A statement detailing the effect that the proposed change will have on the area's pre-hospital services and patient referral patterns;

5) A statement summarizing the steps to be taken to ensure that the necessary quality and level of care will be maintained during the implementation phase of the proposed System;

6) A statement detailing the effect that the proposed System will have on the current radio communications systems utilized in the area;

7) A detailed description of its communications system design, including the expected delivery dates for equipment that has been purchased, leased or ordered; and

8) If the proposed System intends to use, borrow or lease any communications equipment or facilities from an existing System, a

copy of a specific contract or agreement authorizing such arrangement shall be attached;

o) *Written protocols for the transport of persons by ambulance or specialized emergency medical services vehicle to a hospital other than the nearest hospital* or trauma center. (Section 10(c) of the Act)

1) *The protocols shall provide that a person shall not be transported to a hospital other than the nearest hospital,* regional trauma center, or the nearest trauma center, *unless the project medical director or his qualified designee has* determined and *certified that, based upon the reasonable risks and benefits to the patient, and based on the information available at the time:*
   A) *The medical benefits reasonably expected from the provision of appropriate medical treatment at a more distant hospital* or trauma center *outweigh the increased risks to the patient from transport to the more distant hospital* or trauma center, *and*
   B) *The more distant hospital* or trauma center *has available space and qualified personnel for the treatment of the patient.* (Section 10(c) of the Act) An associate hospital, participating hospital, or trauma center affiliated with the EMS System may be presumed to have available space and qualified personnel in accordance with its level of participation within the System, unless such facility has notified the Project Medical Director that it has a shortage or limitation of space or qualified personnel.

2) *The system's protocols may include an accommodation for the patient's choice of hospital other than the nearest hospital* or trauma center *if the transport to the more distant hospital* or trauma center *is not expected to increase the risk to the patient as determined* and certified *by the Project Medical Director or qualified designee.* (Section 10(c) of the Act)

3) In order to certify a determination made pursuant to this subsection, this determination shall be recorded and signed by the Project Medical Director or qualified designee who made such determination at the base station or medical control point that had been contacted by the EMS vehicle personnel. If the person who made the determination is not physically present at such location, the medical control personnel present shall note that on the record, and the person who made the determination shall sign the record as soon thereafter as possible.

4) For purposes of this subsection, the "nearest hospital" is the hospital that is closest to the scene of the emergency as determined by travel time, and that operates a full-time emergency department at the minimum level recognized by the System in its Department-approved Program Plan. The "nearest trauma center" is either the Level I Trauma Center serving the trauma region in which the EMS System is located, or the Level II

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Trauma Center that is closest to the scene of the emergency as determined by travel time.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.215 Approval of Additional Drugs and Equipment

a) The use of all drugs and equipment, other than those covered by the United States Department of Transportation National Standard Curriculum for each EMT level of licensure, must be approved by the Department in accordance with subsections (b), (c) and (d) of this Section before being used in a System.

b) To apply for approval to add drugs and/or equipment, the PMD shall submit to the Department documentation covering the following:
   1) Training program including a description of practical training for equipment and the number of contact hours.
   2) A curriculum for each new drug or equipment, which includes at least the following (as applicable):
      A) Usage
      B) Complications
      C) Adverse actions
      D) Equipment maintenance and use.
   3) New written standing orders.

c) Upon receipt of the application from the System, the Director or his/her designee shall either approve the drug and/or equipment, approve the drug and/or equipment on a conditional basis, or disapprove the drug and/or equipment. The Director's/designee's decision shall be based on a review and evaluation of the documentation submitted under subsection (b) of this Section; the application of technical and medical knowledge and expertise; consideration of relevant literature and published studies on the subject; and whether the drug and/or equipment has been reviewed or tested in the field. The Director may seek the recommendations of medical specialists, and/or other professional consultants to determine whether to approve or disapprove the specific drug(s) and/or equipment.

d) The Director or designee shall consider whether the drugs and equipment may be used safely and with proper training by the pre-hospital care provider, shall disapprove any drugs and equipment which he finds are generally unsafe or dangerous in the pre-hospital care setting.

e) When a drug and/or equipment is approved on a conditional basis, the System shall submit to the Department on a quarterly basis, the following information:
   1) Indications for use;
   2) Number of times used;
   3) Number and types of complications which occurred;
   4) Outcome of patient after use of drug and/or equipment; and

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   5) Description of follow-up actions taken by the System on each case in which complications occurred.

f) When a death or complication which results in a deterioration of a patient's condition occurs involving a drug and/or equipment approved on a conditional basis, the System shall notify the Department within three (3) business days, followed by a written report of the situation and submit that to the Department within ten (10) business days.

g) Failure of the System to submit the information required under subsection (e) of this Section shall be considered as a basis for withdrawal of approval of the drug or equipment on a conditional basis. Failure of the System to notify the Department as required under subsection (f) of this Section shall be considered as a basis for withdrawal of approval of the drug or equipment on a conditional basis.

h) The Director or designee shall evaluate the information submitted under subsection (e) of this Section and any notification required under subsection (f) of this Section. The Department will notify the System that a drug or equipment is disapproved and may no longer be performed on a conditional basis, when the evaluation of the information submitted pursuant to this subsection indicates that the safety of the drug or equipment has not been established for use in the pre-hospital setting.

i) The System may appeal a decision by the Director or designee under this Section by requesting a hearing on the decision within thirty (30) days of notification of the decision. Hearings on appeals will be conducted by the Department in accordance with the Department's administrative hearing rules (77 Ill. Adm. Code 100).

j) A PMD shall not approve an EMT to use new drugs or equipment unless that EMT has completed the Department approved training program and examination, and has demonstrated the required knowledge and skill to use that drug or equipment safely and effectively.

k) A PMD shall not be required to provide new drug or equipment training to System EMTs who will not be utilizing the new drugs or equipment.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.216 Automated Defibrillation

a) *Any person licensed as an EMT-A [EMT-B], EMT-I or EMT-P and affiliated with an EMS system may use an* automated *defibrillator if he or she has completed a course of instruction approved by the Department in* automated *defibrillator* operation. (Section 11.1 of the Act)

b) Automated Defibrillator Operation training is a mandatory component of the EMT-P training established by Section 535.500 of this Part. Separate course approval is therefore not necessary.

c) In order to be approved by the Department, an EMT-B or EMT-I Automated Defibrillator Operation course shall include the following:
   1) A curriculum based on Section 9 of the United States Department

of Transportation, Emergency Medical Technician-Intermediate: National Standard Curriculum;

2) A requirement that an EMT-B or EMT-I shall pass both a written and a practical examination as a condition of completing the course. The examinations shall be developed and evaluated by the Project Medical Director or designee and shall be designed to measure the EMT's knowledge and skills to safely and effectively operate an automated defibrillator.

d) A System may include the course in Automated Defibrillator Operation as part of an initial EMT-B or EMT-I license training program or may offer such training to persons already licensed as an EMT-B or EMT-I.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.217 Do Not Resuscitate (DNR) Policy

a) A System shall develop a DNR policy for use by System personnel. The policy shall be implemented only after it has been reviewed and approved by the Department, in accordance with the requirements of this Section. For purposes of this Section, DNR refers to the withholding of cardiopulmonary resuscitation (CPR), electrical defibrillation, tracheal intubation and manually or mechanically assisted ventilations, unless otherwise stated on the DNR Order.

b) The policy shall include, but not be limited to, specific procedures and protocols for cardiac arrest/DNR situations arising in long-term care facilities, with hospice and home-care patients, and with patients who arrest during interhospital transfers or transportations to or from home.

c) The policy shall include specific procedures and protocols for withholding CPR in situations where explicit signs of biological death are present (e.g., decapitation, rigor mortis without profound hypothermia, profound dependent lividity, etc.), or the patient has been declared dead by a coroner or the patient's physician. The policy shall include recording such information on the run sheet and requesting the physician or coroner to sign the run sheet (if applicable).

d) For situations not covered by subsection (c) of this Section, the policy shall require that resuscitative procedures must be followed unless a valid DNR Order is present.

e) A valid DNR Order shall consist of a written document, which has not been revoked, containing at least the following information:

1) Name of the patient,
2) Name and signature of attending physician,
3) Effective date,
4) The words "Do Not Resuscitate",
5) Evidence of consent - either:
   A) signature of patient or
   B) signature of legal guardian or

   C) signature of durable power of attorney for health care agent or
   D) signature of surrogate decision-maker or
   E) attached living will or other advanced directive prepared by or on behalf of the patient.

f) Revocation of a written DNR Order shall be made only in one or more of the following ways:

1) The Order is physically destroyed or verbally rescinded by the physician who signed the order; or
2) The Order is physically destroyed or verbally rescinded by the person who gave written informed consent to the Order.

g) A System's DNR policy shall require System personnel to make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid DNR Order.

h) The policy shall describe the roles of the on-line medical control physician and mobile intensive care nurse (MICN) in DNR situations.

i) The policy shall state which System ambulance personnel are authorized to respond to a valid DNR Order (EMT-P, EMT-I, EMT-B, Field R.N.).

j) The policy shall cross-reference the System's coroner notification policy.

k) The policy shall describe the System's program for educating System personnel concerning the policy.

l) The policy shall identify the quality assurance measures specific to this policy, including the methods and periods of review, and the submission of a yearly report to the Department indicating issues or problems that have been identified and the System's responses to those issues or problems.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.220 Additions to an Approved Program (Repealed)

(Source: Repealed at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.230 EMS System Personnel Standards

a) The Project Medical Director shall be a physician licensed to practice medicine in all of its branches in Illinois and shall have completed a residency program in emergency medicine approved by the Residency Review Committee of the American Medical Association or have extensive critical or emergency care experience including documented competency in Advanced Life Support. In addition, the Project Medical Director shall:

1) Have experience on an EMS vehicle or make provision to gain such experience within 12 months of the date responsibility for the System is assumed;
2) Be thoroughly knowledgeable of and able to demonstrate all skills

excluding extrication as presented in the Emergency Medical Technician Field RN and MICN training programs; and

3) Have or make provisions to gain experience instructing students at a level similar to that of EMTs, Field RNs and MICNs.

b) The EMS System Coordinator shall:

1) Be a Registered Professional Nurse licensed in the State of Illinois or an EMT-P licensed in the State of Illinois;

2) Be trained and knowledgeable in dysrhythmia identification and treatment and have a diverse background in critical care; and

3) Have or make provision to obtain experience on an EMS vehicle within 12 months of the date the responsibilities of the EMS System Coordinator were assumed.

c) In order to avoid any conflict of interest, the Project Medical Director, EMS System Coordinator and Project Director shall notify the Department in writing of any association with an ambulance service provider through employment or contract, specifying how he or she is answerable to or directed by such ambulance service provider concerning any matter falling within the scope of the Act or this Part. The Department shall review and address potential or actual conflicts of interest on an individual basis.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.240 Minimum Standards for Continuing Operation

a) The Resource Hospital and all System participants shall comply with the terms of the EMS System Program Plan, the System Manual, their respective letters of commitment and any applicable provisions of the Act or this Part;

b) All EMS System personnel and ambulances shall maintain their certifications, licenses and approvals;

c) The System may participate in the AHES plan for its area;

d) The Resource Hospital shall submit to the Department an annual report summarizing System activity; for newly approved Systems, a report covering the first six (6) months of operation shall also be submitted. The report shall include but not be limited to the following items:

1) The number of ALS runs,

2) The number of BLS runs,

3) The number of ILS runs if applicable,

4) The average response time,

5) The number and types of System personnel trained;

e) The Department may suspend or revoke the approval of any EMS System, when its findings show that the System is in violation of one or more of the requirements of this Section. Suspension or revocation depend on the nature of the problem, which rules are violated, severity and number of times.

1) Such suspension or revocation shall be preceded by notice and an

opportunity for a hearing served upon the Project Medical Director by certified mail or personal service,

2) The notice shall set forth the reasons for the proposed suspension or revocation and shall afford the Project Medical Director fifteen (15) days from the date of mailing or personal service to make a written request for an administrative hearing. The PMD's failure to file a written request for a hearing within fifteen (15) days shall be considered a waiver of the System's right to a hearing on the proposed suspension or revocation.

3) All hearings shall be conducted in accordance with the Department's Rules of Practice and Procedure for Administrative Hearings (77 Ill. Adm. Code 100).

(Source: Amended at 13 Ill. Reg. 15414, effective September 15, 1989)

Section 535.250 Resolution of Conflicts (Repealed)

(Source: Repealed at 11 Ill. Reg. 17219, effective October 15, 1987)

Section 535.260 System Participation Suspensions

a) *The Project Medical Director may suspend from participation within the System any EMT or other individual or individual provider within the System considered not to be meeting the standards of that approved system* (Section 13(e) of the Act) based on one or more of the following:

1) failure to meet the education and training requirements prescribed by the Department in Section 535.420, 535.430, 535.520 and 535.530 of this Part or by the Project Medical Director;

2) violation of the Act or this Part;

3) failure to maintain proficiency in the provision of basic, intermediate or advanced life support services;

4) failure to comply with the provisions of the System's Program Plan approved by the Department;

5) intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the delivery, performance or activities in the care of patients requiring medical care (for the purposes of this subsection, adversely affect means anything which could harm the patient or treatment that is administered improperly);

6) intentional falsification of any medical reports or orders, or making misrepresentations involving patient care;

7) abandoning or neglecting a patient requiring emergency care;

8) unauthorized use or removal of narcotics, drugs, supplies or equipment from any amoulance, health care facility, institution or other work place location;

9) performing or attempting emergency care, techniques or procedures

without proper permission, licensure, training or supervision;

10) discriminating in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay;

11) medical misconduct or incompetence, or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care;

12) violation of the System's standards of care;

13) physical impairment of an EMT to the extent that he or she cannot physically perform the emergency care and life support functions for which he or she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part; or

14) mental impairment of an EMT to the extent that he or she cannot exercise the appropriate judgment, skill and safety for performing the emergency care and life support functions for which he or she is licensed, as verified by a physician, unless the EMT is on inactive status pursuant to this Part.

b) *A Project Medical Director may immediately suspend an EMT or other provider if he finds that the information in his possession indicates that the continuation in practice by an EMT or other provider would constitute an imminent danger to the public. The suspended EMT or other provider shall be issued an immediate verbal notification followed by a written suspension order to the EMT or other provider by the Project Medical Director which states the length, terms and basis for the suspension.* (Section 13.2(b) of the Act)

1) *Within 24 hours following the commencement of the suspension, the Project Medical Director shall deliver to the Department, by messenger or telefax, a copy of the suspension order and copies of any written materials which relate to the Project Medical Director's decision to suspend the EMT or provider.* (Section 13.2(b)(1) of the Act)

2) *Within 24 hours following the commencement of the suspension, the suspended EMT or provider may deliver to the Department, by messenger or telefax, a written response to the suspension order and copies of any written materials which the EMT or provider feels relates to that response.* (Section 13.2(b)(2) of the Act)

3) *Within 24 hours following receipt of the Project Medical Director's suspension order or the EMT's or provider's written response, whichever is later, the Director or the Director's designee shall determine whether the suspension should be stayed pending the EMT's or provider's opportunity for hearing or review in accordance with this Act, or whether the suspension should continue during the course of such hearing or review. The Director or the Director's designee shall issue this determination to the Project Medical Director, who shall immediately notify the suspended EMT or provider. The suspension shall remain in effect during this period of review by the Director or the Director's designee.* (Section 13.2(b)(3) of the Act)

4) *The Project Medical Director's suspension order shall include a notice that the EMT or provider shall have the opportunity for a hearing before the system review board, or may elect to bypass the system review board and seek direct review of the Project Medical Director's suspension order by the State EMS Disciplinary Review Board.* (Section 13.2(c) of the Act)

c) For suspensions which do not include a finding by the Project Medical Director of an imminent danger to the public, the Project Medical Director shall issue a written notice to the EMT or provider which includes a statement describing the reason(s) for the suspension, the terms of the suspension, and *the opportunity for a hearing before the system review board prior to the commencement of the suspension.* (Section 13.2 of the Act)

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.265 System Review Board

a) The Project Medical Director shall prepare and post, in a 24-hour accessible location at the Resource Hospital, a System Review Board list for each category of provider within the System which contains the names of six (6) providers in that category. If the total number of providers in a particular category is less than six (6), the list for that category shall contain the names of all of the providers in that category.

b) Upon receipt of a Notice of Suspension from the Project Medical Director, the EMT or other provider shall have fifteen (15) days to request hearing before the System Review Board, by submitting a written request to the PMD via certified mail. Failure to request a hearing within fifteen (15) days shall constitute a waiver of the right to a System Review Board Hearing.

c) Upon receipt of a timely request for a System Review Board Hearing, the PMD shall notify the 2 standing members of the Board that a hearing has been requested. The provider requesting the hearing shall be responsible for consulting the posted lists of providers, and selecting the names of 2 voting members and a chairperson from the provider's category. The PMD shall provide additional names, as needed, if the provider is unable to satisfactorily select 3 names from the initial list of 6.

d) The PMD shall schedule the Board to meet within 3 business days after the provider has selected the 3 remaining members of the Board.

e) The Board shall review and consider any testimony and documentation related to the suspension which is offered by either the PMD or the provider. Both the PMD and the provider may be represented by legal counsel.

f) The Board shall state in writing its decision to affirm, modify or reverse the suspension order. Such decision shall be sent via certified mail or personal service to the PMD and the provider within

5 business days after the conclusion of the hearing.

g) *The Project Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of a hearing and thereafter prepare a transcript of the proceedings.* (Section 13(f) of the Act) A copy of the hearing transcriptions shall be made available to any party so requesting at that party's expense. *The transcript, all documents or materials received as evidence during the hearing and the system review board's written decision shall be retained in the custody of the EMS system.* (Section 13(f) of the Act)

h) The Project Medical Director shall notify the Department, in writing, of a decision by the Review Board to either uphold or reverse the Project Medical Director's suspension of an individual or individual provider from participation within the System, within five (5) business days after the Board's decision. Such notice shall include a statement detailing the duration of and grounds for the suspension.

i) A recommendation to the Illinois Department of Public Health by a Project Medical Director to deny, suspend or revoke the license of a participant within an EMS System is not subject to the provisions of this Section, unless such recommendation forms the basis for suspension pursuant to Section 535.260(a) of this Part.

j) *The system shall implement a decision of the system review board unless that decision has been appealed to the State EMS Disciplinary Review Board.* (Section 13(f) of the Act)

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.270 State EMS Disciplinary Review Board

a) The State Emergency Medical Services Disciplinary Review Board shall be composed of five members and five alternate members appointed by the Governor. *The 5 members of the Board shall be: a Project Medical Director from a Department-approved EMS System, a Hospital Administrator from a Department - approved EMS System, an EMS Coordinator from a Department - approved EMS System, a licensed Emergency Medical Technician - Paramedic (EMT-P) and a licensed Emergency Medical Technician - Ambulance (EMT-A) [EMT-B].* (Section 10.1 of the Act)

b) *There shall be one alternate for each member of the Board, from the same professional category as the member of the Board.* (Section 10.1 of the Act)

c) *Of the members first appointed to the State EMS Disciplinary Review Board by the Governor, one member shall be appointed for a term of one year. 2 members shall be appointed for a term of 2 years and 2 members shall be appointed for a term of 3 years. The terms of subsequent appointees shall be 3 years. All appointees shall serve until their successors are appointed. The alternate members shall be appointed and serve in the same fashion as the members of the Board. If a member resigns his or her appointment, the corresponding alternate shall serve the remainder of that member's term until a subsequent member is appointed by the Governor.* (Section 10.1 of the Act)

d) *The function of the State EMS Disciplinary Review Board is to review and affirm, reverse or modify orders to suspend an EMT or other individual provider from participating within an EMS System.* (Section 10.2(a) of the Act)

e) *An EMT or other provider who has been suspended by a Project Medical Director for reasons directly related to patient care may request the board to reverse or modify the suspension order. Such a request shall be made in writing by certified mail to the chief of the Department's Division of Emergency Medical Services and Highway Safety, Springfield, Illinois, within 10 days after receiving the Project Medical Director's suspension order. A copy of the PMD's written suspension order shall be enclosed.* (Section 10.2(b) of the Act)

f) *A suspended EMT or other provider whose suspension was affirmed or modified by a local system review board may request the board to reverse or modify the local board's decision, and a Project Medical Director whose suspension order was reversed or modified by a local system board may request the board to reverse or modify the local board's decision. Such requests shall be made in writing by certified mail to the Chief of the Department's Division of Emergency Medical Services and Highway Safety, Springfield, Illinois, within 10 days after receiving the local Board's decision. A copy of the local Board's decision shall be enclosed.* (Section 10.2(c) of the Act)

g) *Upon receipt of a valid request for review, the Department shall notify the members of the Board as well as the alternates for Board members who are unavailable. A Quorum shall consist of 3 members or alternates and shall include the Project Medical Director Board member or alternate. The Board shall meet within 14 days after the Department receives the request for review, or as soon thereafter as the Project Medical Director Board member or alternate is available. The Board shall meet in Chicago or Springfield, whichever location is closer to the involved EMS System.* (Section 10.2(d) of the Act)

h) *At each meeting of the Board, the members or alternates present at the meeting shall select a chairperson to conduct the meeting. The Board shall review the transcripts, evidence and written decision of the Local Review Board, or the written decision and supporting documentation of the PMD, whichever is applicable. The suspended participant and the Project Medical Director shall each have the opportunity to present a written statement specifying why the Local Review Board's decision or the PMD's suspension order should be affirmed, reversed, or modified. The Board shall allow such testimony and new evidence as it deems necessary to determine whether the Local Board's decision or the PMD's suspension order was supported by the weight of the evidence. The Project Medical Director shall provide the Board with the transcript, evidence and written decision of the Local Review Board, or the supporting documentation on which his or*

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her suspension order was based, whichever is applicable. The Project Medical Director shall arrange for a certified shorthand reporter to make a stenographic record of the Board's meeting and thereafter prepare a transcript of the proceedings. (Section 10.2(e) of the Act)

i) *At the conclusion of any testimony or presentation of new evidence, the Board shall meet in a closed session to reach a decision. The Board may continue its meeting to another date for further deliberation; however, the Board shall render a decision not more than 28 days after the first meeting date. On a form provided by the Department, the chairperson of the meeting shall state the Board's decision to affirm, reverse or modify the decision of the Local Review Board or the EMD's suspension order, whichever is applicable, and state the basis for the Board's decision. The chairperson shall* within five working days *submit the Board's written decision, together with the transcripts, evidence and other materials from the meeting, to the Department. The Department shall* within five working days *issue a copy of the Board's decision to all affected parties.* (Section 10.2(f) of the Act)

j) *The system shall implement a decision of the State EMS* Disciplinary *Review Board which has been rendered in accordance with the Act and* this Part. (Section 13(g) of the Act)

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

SUBPART E: EMERGENCY MEDICAL TECHNICIAN - BASIC (EMT-B)

Section 535.300 Emergency Medical Technician - Basic Training - General

a) Applications for approval of EMT-B Training Programs shall be filed with the Department on forms prescribed, prepared and furnished by the Department. The application shall contain such information as, but not limited to, name of applicant, agency and address, type of training program, lead instructor's name and address, dates of the training program, name and signature of medical director.

b) Applications for approval shall be submitted at least 60 days in advance of the first scheduled class.

c) The EMT-B training program shall designate a physician as Medical Director who is knowledgeable in emergency care. The Medical Director shall attest that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum, and that all instructors are knowledgeable in the material and capable of instructing at the EMT-B level.

d) The EMT-B training program shall designate a Lead Instructor who shall be responsible for the overall management of the training program.

e) The Lead Instructor shall be an EMT-B, EMT-I, EMT-P, an Illinois Registered Nurse, or a physician licensed to practice medicine in all of its branches in Illinois.

f) The Lead Instructor shall have three years of experience in emergency

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care as a provider and two years of teaching experience in a classroom setting.

g) The Lead Instructor shall be recommended by the Medical Director and approved by the Department based on the requirements of Section 535.300(e) and (f).

h) Any changes in the EMT-B training program's Medical Director or Lead Instructor shall require the application process outlined in Section 535.300(a).

i) Questions for all quizzes and tests to be given during the EMT-B training program will be prepared by the Department and provided to the Lead Instructor upon request, or the Lead Instructor may choose to prepare his/her own quizzes and tests.

j) Each approved training program shall submit a student roster within 10 days after the first class as well as a student roster indicating successful or unsuccessful completion within 10 days after the last class.

k) All approved programs shall maintain class and student records for seven years and these shall be made available to the Department upon request.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.310 EMT-B Testing

a) After completion of an approved training program, EMT-B candidates shall take a written examination. The candidate shall have the choice of taking either the National Registry of Emergency Medical Technicians examination or the Department's examination. The Department's examination is based on the United States Department of Transportation National Standard Curriculum and is equivalent to the National Registry Examination.

b) The Department or designee shall administer the National Registry examination or the State written examination for EMT-B licensure at least once each quarter and at a location in each administrative region in the State.

c) All EMT-B candidates shall hold a high school diploma or high school equivalency certificate and be 18 years of age or older in order to be tested for licensure.

d) A failure rate per class of 25 percent or greater on the licensure examination shall require that the particular EMT-B training program be reevaluated by the Department at least 60 days before the start of the next class.

e) Failure to achieve a passing grade on three successive examinations within 12 months of the completion of the Training Program shall require the candidate to retake the EMT-B training program.

f) When a candidate elects to take the State examination or the National Registry's examination, the candidate must successfully complete that particular testing procedure. A candidate will not be allowed to take

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the alternate examination after failure to achieve a passing grade.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.315 Fee For Testing

a) Each EMT-B candidate making application for the Department's written examination for licensure is required to submit a fee of $10.00. This fee is to be paid by certified check or money order. Cash will not be accepted.
b) Failure to appear for the examination on the scheduled date, at the time and place specified, shall result in the forfeiture of the examination fee.
c) If an EMT-B candidate does not achieve a passing grade on the written examination, the fee for the retest is the same as for initial examination.
d) All fees submitted for licensure examinations are not refundable.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.320 EMT-B Licensure

a) In order to be licensed by the Department as an EMT-B an individual must pass the National Registry of Emergency Medical Technicians Examination or the Department's EMT-B examination.
b) The Department will license those individuals who meet the requirements of this Section for a period of four years.
c) A licensed EMT-B shall perform only those life support services covered by the EMT-B training and testing required by this Part. Only EMT-Bs who have been approved by their EMS System Project Medical Director to operate an automated defibrillator, pursuant to Section 535.216 of this Part, shall be allowed to do so.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.330 EMT-B Relicensure

a) In order to be relicensed as an EMT-B:
   1) The EMT-B licensee must file with the Department an application for renewal on a form provided by the Department at least 30 days prior to the four year license expiration date. The application shall be filed with the Department's Regional EMS Coordinator for the Region in which the EMT-B resides.
   2) Written documentation must be provided to the Regional EMS Coordinator by the Project Medical Director or the EMT-B regarding completion of the following requirements:
      A) A 20-hour refresher training program, to be successfully completed during the last two years of the relicensure period.
      B) One hundred additional hours of continuing education, seminars and workshops with 60 hours completed during the first two years and 40 hours completed during the last two years of the relicensure period, no more than 25 percent to be in any single area, i.e., extrication, cardiac, etc.
      C) Any System continuing education requirements for EMT-Bs approved to operate an automated defibrillator shall be included in the 100 required continuing education hours.
      D) A current CPR certificate, which covers:
         i) Adult one-rescuer CPR
         ii) Adult foreign body airway obstruction management
         iii) Pediatric one-rescuer CPR
         iv) Pediatric foreign body airway obstruction management
         v) Adult two-rescuer CPR
         vi) Pediatric two-rescuer CPR.
b) Composition of refresher training programs and qualifications of instructors shall be approved by the Department not less than 60 days prior to the scheduled event. Program approval will be granted provided the program is conducted in accordance with guidelines of the Federal Department of Transportation's national curriculum and based upon the program content relevancy for EMT-Bs. Qualifications of instructors shall be consistent with Section 535.300(e) and (f).
c) The license of an EMT-B who has failed to file an application for renewal, or whose application for renewal has been denied by the Department, shall terminate on the day following the expiration date shown on the license.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.335 EMT-B Continuing Education

a) Continuing education classes, seminars, workshops or other types of programs shall be approved by the Department before being offered to EMT-Bs. An application for approval shall be submitted to the Department on a form prescribed, prepared and furnished by the Department, at least 60 days prior to the scheduled event.
b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for EMT-Bs. Upon approval, the Department will issue a site code to the class, seminar, workshop or program.
c) An EMT-B shall be responsible for submitting written proof of continuing education attendance to the EMS System Coordinator or the Department Regional EMS Coordinator.
d) The EMS System Coordinator or Department Regional EMS Coordinator shall be solely responsible for verifying whether specific continuing education hours have been earned by the EMT-B.

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e) An EMT-B shall be responsible for maintaining copies of all documentation concerning continuing education programs that he or she has completed.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.340 Failure to Renew - Denial of Relicensure

Every EMT-B licensee who either fails to apply for renewal prior to the expiration of the license, whose application for renewal is denied by the Department, or whose license has been revoked by the Department shall be required to retake the training program and tests and pay the fees as required for initial licensure, in order to be relicensed.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.350 Penalty (Repealed)

(Source: Repealed at 14 Ill. Reg. 15390, effective September 1, 1990)

SUBPART F: EMERGENCY MEDICAL TECHNICIAN - INTERMEDIATE (EMT-I)

Section 535.400 Emergency Medical Technician - Intermediate Training - General

a) An EMT-I training program shall only be conducted by an EMS System.
b) Applications for approval of EMT-I Training Programs shall be filed with the Department on forms prescribed, prepared and furnished by the Department. The application shall contain such information as, but not limited to, name of applicant, agency and address, type of training program, lead instructor's name and address, dates of training program, name and signature of the Project Medical Director and EMS System Coordinator.
c) Applications for approval shall be submitted at least 60 days in advance of the first scheduled class.
d) The Project Medical Director of the EMS System shall attest on the Department's application form that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum. Minimum sections shall include #1 through #8.
e) The EMT-I training program shall be under the direction of the Project Medical Director and the EMS System Coordinator.
f) The EMS system shall designate a Lead Instructor, who shall be approved by the Department based on the requirements of Section 535.400(g).
g) The Lead Instructor shall be an EMT-I, EMT-P, a Registered Nurse or a physician and shall have three years of experience in emergency care

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as a provider and two years of teaching experience in a classroom setting.
h) Any changes in the EMT-I training program's Project Medical Director, EMS System Coordinator and/or Lead Instructor shall require the application process as outlined in subsection (b) of this Section.
i) A candidate for an EMT-I training program must have a current Illinois EMT-B license.
j) Before a candidate is accepted into the program, documentation must be submitted that an EMS System vehicle will be available to accommodate field experience and internship needs.
k) Each approved training program shall submit a student roster within 10 days after the first class.
l) After an EMT-I candidate has completed and passed all components of the training program, the PMD shall submit to the Department a transaction card (Form No. IL 482-0837) concerning that individual.
m) All approved programs shall maintain class and student records for seven years and these shall be made available to the Department upon request.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.410 EMT-I Testing

a) After completion of an approved training program, EMT-I candidates shall take a written examination. The candidate shall have the choice of taking either the National Registry of Emergency Medical Technicians examination or the Department's examination. The Department's examination is based on the United States Department of Transportation National Standard Curriculum and is equivalent to the National Registry Examination.
b) The Department or designee shall administer the State written examination for EMT-I licensure on a semi-annual schedule. Candidates who elect to take the National Registry of Emergency Medical Technicians examination in lieu of the State examination shall be responsible for making their own arrangements with the National Registry.
c) A failure rate per class of 25% or greater on the licensure examination shall require that the particular EMT-I training program be reevaluated by the Department at least sixty (60) days before the start of the next class.
d) Failure to achieve a passing grade on three successive examinations within 12 months of the completion of the Training Program shall require the candidate to retake the EMT-I training program.
e) When a candidate elects to take the State examination or the National Registry's examination, the candidate must successfully complete that particular testing procedure. A candidate will not be allowed to take the alternate examination after failure to achieve a passing grade.

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(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.415 Fee For Testing

a) Each EMT-I candidate making application for the Department's written examination for licensure is required to submit a fee of Fifteen Dollars ($15.00). This fee is to be paid by certified check or money order. Cash will not be accepted.
b) Failure to appear for the examination on the scheduled date, at the time and place specified, shall result in the forfeiture of the examination fee.
c) If an EMT-I candidate does not achieve a passing grade on the written examination, the fee for the retest is the same as for initial examination.
d) All fees submitted for licensure examinations are not refundable.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.420 EMT-I Licensure

a) In order to be licensed by the Department as an EMT-I, an individual must:
   1) Pass either the National Registry of Emergency Medical Technicians examination or the Department's EMT-I examination.
   2) Complete a field internship on a State-approved EMS System vehicle, supervised by an EMT-I or EMT-P with one year of experience, a Registered Professional Nurse designated by the Project Medical Director, or a physician with critical care knowledge and experience on an EMS vehicle.
      A) The length and structure of the field internship shall be determined by the PMD for the System in which the internship is performed, based upon the types and frequencies of emergency calls encountered by EMT-Is within that System, but shall include a minimum of five Intermediate Life Support runs.
      B) The field internship shall be completed within six months after passing the EMT-I examination. If an extension of time is needed due to hardship, a waiver shall be sought pursuant to Section 535.750 of this Part, prior to the end of the six-month period.
      C) An EMT-I candidate who completes the internship after the six-month period, pursuant to waiver, shall be given a practical examination by the PMD. Such examination shall cover patient assessment and appliance application at the EMT-I level.
      D) The PMD shall notify the Department, in writing, when an EMT-I candidate has completed the field internship and passed a practical examination, if applicable.

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   3) Be functioning within a State-approved EMS System providing intermediate life support services, as verified by that System's Project Medical Director.
b) The Department will license those individuals who meet the requirements of this Section for a period of four years.
c) A licensed EMT-I shall perform only those life support services covered by the EMT-I training and testing required by this Part. Only EMT-Is who have been approved by their EMS System Project Medical Director to operate an automated defibrillator, pursuant to Section 535.216 of this Part, will be allowed to do so.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.430 EMT-I Relicensure

a) In order to be relicensed as an EMT-I:
   1) The EMT-I licensee must file with the Department an application for renewal on a form prepared by the Department at least 30 days prior to the four year license expiration date.
      A) The submission of a transaction card (Form No. IL 482-0837) by the Project Medical Director will satisfy the renewal application requirement for a licensee who has been recommended for relicensure by the Project Medical Director.
      B) A licensee who has not been recommended for relicensure by the Project Medical Director must independently submit to the Department an application for renewal. The Project Medical Director shall provide the licensee with a copy of the appropriate form to be completed.
   2) A written recommendation signed by the Project Medical Director must be provided to the Department regarding completion of the following requirements:
      A) A 20-hour refresher training program, to be successfully completed during the last two years of the relicensure period.
      B) One hundred additional hours of continuing education, seminars and workshops, with 60 hours completed during the first two years and 40 hours completed during the last two years of the relicensure period, no more than 25 percent to be in any single area, i.e., extrication, cardiac, etc.
      C) Any System continuing education requirements for EMT-Is approved to operate an automated defibrillator shall be included in the required 100 continuing education hours.
      D) A current CPR certificate that covers:
         i) Adult one-rescuer CPR
         ii) Adult foreign body airway obstruction management
         iii) Pediatric one-rescuer CPR
         iv) Pediatric foreign body airway obstruction management
         v) Adult two-rescuer CPR

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vi) Pediatric two-rescuer CPR.

E) Functioning within a State-approved EMS System providing intermediate life support services as verified by that System's Project Medical Director.

b) Composition of refresher training programs and qualifications of instructors and continuing education programs shall be submitted to the Department for approval not less than 60 days prior to the scheduled event. Program approval will be granted provided the program is conducted in accordance with guidelines of the Federal Department of Transportation's national curriculum and contains material relevant to EMT-Is. Qualifications of instructors shall be consistent with Section 535.400(f).

c) Upon denial of recommendation for relicensure, the Project Medical Director shall submit all reasons for denial. This denial shall be in writing and sent to the EMT-I and the Department.

d) The licensure of an EMT-I who has failed to file an application for renewal, or whose application for renewal has been denied by the Department, shall terminate on the day following the expiration date shown on the license.

e) At any time prior to the expiration of the current license, the EMT-I may revert to the EMT-B status for the remainder of the license period. The EMT-I must make this request in writing to the Department. To relicense at the EMT-B level, the individual must meet the requirements for relicensure found in Section 535.330.

f) An EMT-I who has reverted to EMT-B status may be subsequently relicensed as an EMT-I, upon the recommendation of a Project Medical Director who has verified that the individual's knowledge and clinical skills are at an active EMT-I level, and the individual has completed any retraining, education or testing deemed necessary by the PMD for resuming EMT-I activities.

g) An *EMT-I license that expired while the licensee was temporarily disabled or was suspended* based on a temporary disability *shall be reinstated when the disability ceases, upon application and payment of any applicable fee and verification by the Project Medical Director that the licensee is capable of functioning at the EMT-I level, based upon the PMD's assessment of the licensee's knowledge and clinical skills and the licensee's completion of any refresher training deemed necessary by the PMD and approved by the Department.* (Section 10(g) of the Act, see P.A. 88-564)

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.432 EMT-I Continuing Education

a) Didactic continuing education classes, seminars or other types of programs shall be approved by the Department before being offered to EMT-Is. An application for approval shall be submitted to the Department by a Project Medical Director, on a form prescribed,

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prepared and furnished by the Department, at least sixty (60) days prior to the scheduled event.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for Intermediates. Upon approval, the Department will issue a site code to the class, seminar or program.

c) An EMS System may apply to the Department for a single System Site Code to cover didactic continuing education activities conducted by the System solely for System EMT-Is (e.g., telemetry review at the Resource Hospital, morbidity and mortality conferences, preceptor orientation, review of System education materials). Activities conducted under the System Site Code shall not require individual approval by the Department.

d) The PMD of the EMS System in which the EMT-I functions shall be responsible for determining whether a particular State-approved didactic continuing education program is acceptable for credit within the System.

e) An EMT-I shall be responsible for submitting written proof of didactic continuing education attendance to the EMS System Coordinator, in the manner prescribed by the System Program Plan.

f) The EMS System Coordinator or Project Medical Director of the EMS System in which an EMT-I primarily functions shall be solely responsible for verifying whether specific continuing education hours have been earned by the EMT-I.

g) An EMS System which requires clinical continuing education shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted and verified.

h) An EMT-I shall be responsible for maintaining copies of all documentation concerning continuing education programs or activities that he or she has completed.

(Source: Added at 14 Ill. Reg. 15390, effective September 1, 1990)

Section 535.435 Failure to Renew-Denial of Relicensure

Every EMT-I licensee who either fails to apply for renewal prior to the expiration of the license, whose application for renewal is denied by the Department, or whose license has been revoked by the Department shall be required to retake the training program and tests and pay the fees as required for initial licensure, in order to be relicensed.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.440 EMT-I Inactive Status

a) Prior to the expiration of the current license, an EMT-I may request

to be placed on inactive status. The request shall be made in writing to the Project Medical Director. The Project Medical Director will apply to the Department in writing and request that the EMT-I be placed on inactive status. This application shall contain the following information:

1) Name of individual.
2) Date of licensure.
3) EMT identification number.
4) Circumstances requiring inactive status.
5) Length of time of inactive status.
6) A statement that relicensure requirements have been met by the date of the application for inactive status.

b) The Department will review requests for inactive status. The Department shall notify the Project Medical Director in writing of its decision based on subsection (a) of this Section.

c) In order for the EMT-I to return to active status, the Project Medical Director must make application to the Department. The application must be in writing and include a statement that the EMT has been examined (physically and mentally) and found capable of functioning within the EMS System, that the EMT-I's knowledge and clinical skills are at an active EMT-I level and that the EMT-I has completed any refresher training deemed necessary by the PMD and approved by the Department. If the inactive status was based on a temporary disability, the PMD shall also verify that the disability has ceased.

d) During inactive status, the EMT-I shall not function as an EMT, at any level.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.450 Penalty (Repealed)

(Source: Repealed at 14 Ill. Reg. 15390, effective September 1, 1990)

SUBPART G: EMERGENCY MEDICAL TECHNICIAN - PARAMEDIC (EMT-P)

Section 535.500 Emergency Medical Technician-Paramedic Training - General

a) An EMT-P training program shall only be conducted by an EMS System.

b) Applications for approval of EMT-P training programs shall be filed with the Department on forms prescribed, prepared and furnished by the Department. The application shall contain such information as, but not limited to, name of applicant, agency and address, type of training program, Project Medical Director's and EMS System Coordinator's name, dates of training program, signature of Project Medical Director and EMS System Coordinator.

c) Applications for approval shall be submitted at least 60 days in

advance of the first scheduled class.

d) The Project Medical Director of the EMS System shall attest that the training program shall be conducted according to the United States Department of Transportation's National Standard Curriculum. The EMT-P training program shall include all components of the National Standard Curriculum.

e) The EMT-P training program's lead coordinators shall be the Project Medical Director and the EMS System Coordinator.

f) Any change in the EMT-P training program's Project Medical Director and/or EMS System Coordinator shall require the application process as outlined in subsection (b) of this Section.

g) A candidate for an EMT-P training program must have a current Illinois EMT-B or EMT-I license.

h) Before a candidate is accepted into the program, documentation must be submitted that an EMS System vehicle will be available to accommodate field experience and internship needs.

i) Each approved training program shall submit a student roster within 10 days after the first class.

j) After an EMT-P candidate has completed and passed all components of the training program, the PMD shall submit to the Department a transaction card (Form No. IL 482-0837) concerning that individual.

k) All approved programs shall maintain class and student records for seven years and these shall be made available to the Department upon request.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.510 EMT-P Testing

a) After completion of an approved training program, EMT-P candidates shall take a written examination. The candidate shall have the choice of taking either the National Registry of Emergency Medical Technicians examination or the Department's examination. The Department's examination is based on the United States Department of Transportation National Standard Curriculum and is equivalent to the National Registry Examination.

b) The Department or designee shall administer the State written examination for EMT-P licensure on a semi-annual schedule. Candidates who elect to take the National Registry of Emergency Medical Technicians examination in lieu of the State examination shall be responsible for making their own arrangements with the National Registry.

c) Failure to achieve a passing grade on three successive examinations within 12 months of the completion of the Training Program shall require the candidate to retake the EMT-P training program.

d) When a candidate elects to take the State examination or the National Registry's examination, the candidate must successfully complete that particular testing procedure. A candidate will not be allowed to take

the alternate examination after failure to achieve a passing grade.

e) A failure rate per class of twenty-five (25%) percent or greater shall require that the particular EMT-P training program be reevaluated by the Department at least sixty (60) days prior to the start of the next class.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.515 Fee For Testing

a) Each EMT-P candidate making application for the Department's written examination for licensure is required to submit a fee of Twenty-five Dollars ($25.00). This fee is to be paid by certified check or money order. Cash will not be accepted.

b) Failure to appear for the examination on the scheduled date, at the time and place specified, shall result in the forfeiture of the examination fee.

c) If an EMT-P candidate does not achieve a passing grade on the written examination, the fee for the retest is the same as for initial examination.

d) All fees submitted for licensure examinations are not refundable.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.520 EMT-P Licensure

a) In order to be licensed by the Department as an EMT-P an individual must:

1) Pass either the National Registry of Emergency Medical Technicians examination or the Department's EMT-P examination; and

2) Complete a field internship on a State-approved EMS System vehicle, supervised by an EMT-P with one year of experience, a Registered Professional Nurse designated by the Project Medical Director, or a physician with critical care knowledge and experience on an EMS vehicle.

A) The length and structure of the field internship shall be determined by the PMD for the System in which the internship is performed, based on the types and frequencies or emergency calls encountered by EMT-Ps within that System, but shall include a minimum of 10 Advanced Life Support runs.

B) The field internship shall be completed within 12 months after passing the EMT-P examination. If an extension of time is needed due to hardship, a waiver shall be sought pursuant to Section 535.750 of this Part, prior to the end of the 12-month period.

C) An EMT-P candidate who completes the internship after the 12-month period, pursuant to waiver, shall be given a practical examination by the PMD. Such examination shall cover patient assessment and appliance application at the EMT-P level.

D) The PMD shall notify the Department, in writing, when an EMT-P candidate has completed the field internship and passed a practical examination, if applicable; and

3) Be functioning within a State-approved EMS System providing advanced life support services, as verified by that System's Project Medical Director.

b) The Department will license those individuals who meet the requirements of this Section for a period of four years.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.530 EMT-P Relicensure

a) In order to be relicensed as an EMT-P:

1) The EMT-P licensee must file with the Department an application for renewal on a form prepared by the Department at least 30 days prior to the four year license expiration date.

A) The submission of a transaction card (Form No. IL 482-0837) by the Project Medical Director will satisfy the renewal application requirement for a licensee who has been recommended for relicensure by the Project Medical Director.

B) A licensee who has not been recommended for relicensure by the Project Medical Director must independently submit to the Department an application for renewal. The Project Medical Director shall provide the licensee with a copy of the appropriate form to be completed.

2) A written recommendation signed by the Project Medical Director must be provided to the Department regarding completion of the following requirements:

A) Sixty hours of continuing education, seminars and workshops during each two-year portion of the relicensure period, not more than 25 percent to be in any single area, i.e., extrication, cardiac, etc.

B) A current CPR certificate, which covers:

i) Adult one-rescuer CPR
ii) Adult foreign body airway obstruction management
iii) Pediatric one-rescuer CPR
iv) Pediatric foreign body airway obstruction management
v) Adult two-rescuer CPR
vi) Pediatric two-rescuer CPR.

C) Functioning within a State-approved EMS System providing advanced life support services as verified by that System's Project Medical Director.

b) Upon denial of recommendation for relicensure, the Project Medical

Director must submit all reasons for denial. This denial shall be in writing and sent to the EMT-P and the Department.

c) The license of an EMT-P who has failed to file an application for renewal, or whose application for renewal has been denied by the Department, shall terminate on the day following the expiration date shown on the license.

d) At any time prior to the expiration date of the current license, the EMT-P may revert to either the EMT-I or EMT-B status for the remainder of the license period. The EMT-P must make this request in writing to the Department and in the case of reduction to the EMT-I level, the request must include a letter of recommendation from the Project Medical Director. To relicense at the EMT-B level, the individual must meet the requirements for relicensure found in Section 535.330. To relicense at the EMT-I level, the individual must meet the requirements for relicensure found in Section 535.430.

e) An EMT-P who has reverted to EMT-I or EMT-B status may be subsequently relicensed as an EMT-P, upon the recommendation of a Project Medical Director who has verified that the individual's knowledge and clinical skills are at an active EMT-P level, and the individual has completed any retraining, education or testing deemed necessary by the PMD for resuming EMT-P activities.

f) An *EMT-P license that expired while the licensee was temporarily disabled or was suspended* based on a temporary disability *shall be reinstated when the disability ceases, upon application and payment of any applicable fee and verification by the project medical director that the licensee is capable of functioning at the EMT-P level, based upon the PMD's assessment of the licensee's knowledge and clinical skills and the licensee's completion of any refresher training deemed necessary by the PMD and approved by the Department.* (Section 10(g) of the Act, see P.A. 88-564)

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.532 EMT-P Continuing Education

a) Didactic continuing education classes, seminars or other types of programs shall be approved by the Department before being offered to EMT-Ps. An application for approval shall be submitted to the Department by a Project Medical Director, on a form prescribed, prepared and furnished by the Department, at least sixty (60) days prior to the scheduled event.

b) Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the United States Department of Transportation National Standard Curriculum for Paramedics. Upon approval, the Department will issue a site code to the class, seminar or program.

c) An EMS System may apply to the Department for a single System Site Code to cover didactic continuing education activities conducted by

the System solely for System EMT-Ps (e.g., telemetry review at the Resource Hospital, morbidity and mortality conferences, preceptor orientation, review of System educational materials). Activities conducted under the System Site Code shall not require individual approval by the Department.

d) The PMD of the EMS System in which the EMT-P functions shall be responsible for determining whether a particular State-approved didactic continuing education program is acceptable for credit within that System.

e) An EMT-P shall be responsible for submitting written proof of didactic continuing education attendance to the EMS System Coordinator, in the manner prescribed by the System Program Plan.

f) The EMS System Coordinator or Project Medical Director of the EMS System in which an EMT-P primarily functions shall be solely responsible for verifying whether specific continuing education hours have been earned by the EMT-P.

g) An EMS System which requires clinical continuing education shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted and verified.

h) An EMT-P shall be responsible for maintaining copies of all documentation concerning continuing education programs or activities that he or she has completed.

(Source: Added at 14 Ill. Reg. 15390, effective September 1, 1990)

Section 535.535 Failure to Renew-Denial of Relicensure

Every EMT-P licensee who either fails to apply for renewal prior to the expiration of the license, whose application for renewal is denied by the Department, or whose license has been revoked by the Department shall be required to retake the training program and tests and pay the fees as required for initial licensure, in order to be relicensed.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

Section 535.540 EMT-P Inactive Status

a) Prior to the expiration of the current license, an EMT-P may request to be placed on inactive status. The request shall be made in writing to the Project Medical Director. The Project Medical Director will apply to the Department in writing and request that the EMT-P be placed on inactive status. This application shall contain the following information:

1) Name of individual.
2) Date of licensure.
3) EMT identification number.
4) Circumstances requiring inactive status.

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5) Length of time of inactive status.
6) A statement that relicensure requirements have been met by the date of the application for inactive status.

b) The Department will review requests for inactive status. The Department shall notify the Project Medical Director in writing of its decision based on subsection (a) of this Section.

c) In order for the EMT-P to return to active status, the Project Medical Director must make application to the Department. The application must be in writing and include a statement that the EMT has been examined (physically and mentally) and found capable of functioning within the EMS System, that the EMT-P's knowledge and clinical skills are at an active EMT-P level and that the EMT-P has completed any refresher training deemed necessary by the PMD and approved by the Department. If the inactive status was based on a temporary disability, the PMD shall also verify that the disability has ceased.

d) During inactive status, the EMT-P shall not function as an EMT, at any level.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.550 Penalty (Repealed)

(Source: Repealed at 14 Ill. Reg. 15390, effective September 1, 1990)

SUBPART H: RECIPROCITY

Section 535.600 Reciprocity

a) EMT's from other states who wish to function in Illinois as an Emergency Medical Technician may apply to the Department for licensure by reciprocity.

b) Such application shall be in writing and contain the following information:
1) Proof of current registration by the State in which they currently function and written verification from that State.
2) A written statement of satisfactory completion of a training program that meets or exceeds the requirements of the Department as set forth in this Part.
3) In the case of an EMT-I or EMT-P, a letter of recommendation from the Project Medical Director of the EMS System in which the individual will function.
4) A current CPR Certification.

c) The Department will review requests for reciprocity to determine compliance with the applicable provisions of this Part.

d) Individuals who meet the requirements for licensure by reciprocity will be State licensed consistent with the expiration date of their current license but not to exceed a period of two (2) years.

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e) Following licensure by reciprocity, the individual must comply with the requirements of this Part for relicensure.

(Source: Amended 17 Ill. Reg. 8196, effective May 21, 1993)

SUBPART I: SUSPENSION, REVOCATION AND DENIAL OF LICENSURE OF EMTs

Section 535.650 Suspension, Revocation and Denial of Licensure of EMTs

a) The Director, after providing notice and an opportunity for an administrative hearing to the applicant or licensee, shall deny, suspend or revoke a license or refuse to relicense any person as an EMT-B, EMT-I or EMT-P in any case in which he or she finds that there has been a substantial failure to comply with the provision of the Emergency Medical Services (EMS) Systems Act or this Part. Such findings must show one or more of the following:
1) *The EMT-A* [EMT-B], *EMT-I or EMT-P has not met continuing and additional education and training requirements as prescribed by the Department* in this Part (Section 10(b)(1) of the Act);
2) *The EMT-A* [EMT-B], *EMT-I or EMT-P has violated the Act or any rule promulgated under the Act* (Section 10(b)(2) of the Act);
3) *The EMT-A* [EMT-B], *EMT-I or EMT-P has failed to maintain proficiency in providing basic or intermediate life support services, or advanced life support-mobile intensive care services or required skills as prescribed by the Department (Section 10(b)(3) of the Act);*
4) *The EMT-A* [EMT-B], *EMT-I, or EMT-P, during the provision of emergency services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public* (e.g., use of alcohol or illegal drugs while on duty, verbal or physical abuse of a patient, or misrepresentation of licensure status) (Section 10(b)(4) of the Act);
5) *The EMT-A* [EMT-B], *EMT-I or EMT-P is physically impaired to the extent that he or she cannot physically perform the emergency care and life support functions for which he or she is licensed, as verified by a physician, unless the person is an EMT-I or EMT-P on inactive status pursuant to Department regulations* (Section 10(b)(5) of the Act); or
6) *The EMT-A* (EMT-B], *EMT-I or EMT-P is mentally impaired to the extent that he or she cannot exercise the appropriate judgment, skill and safety for performing the emergency care and life support functions for which he or she is licensed, as verified by a physician, unless the person is an EMT-I or EMT-P on inactive status pursuant to Department regulations.* (Section 10(b)(6) of the Act)

b) "Substantial Failure", as used in this Section, means a failure other

than a variance from the strict and literal requirements, which results in unimportant omissions, given the particular circumstances involved.

c) "Revocation", as used in this Section, means that the Department-issued license is terminated.

d) "Suspension", as used in this Section, means that the Department-issued license is invalid for an identified period of time determined necessary to correct substantial failure.

e) The Director shall suspend a license in any case in which he or she finds that the substantial failure by the licensee can be corrected or remedied within an identified period of time determined necessary to correct the substantial failure prior to the expiration of the license. If the substantial failure cannot be corrected or remedied within an identified period of time prior to the expiration of the license, then the Director shall revoke the license.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

SUBPART J: DATA COLLECTION AND EVALUATION

Section 535.700 Data Collection and Evaluation

a) All Resource Hospitals that direct pre-hospital care at the Intermediate Life Support and/or Advanced Life Support Levels in the State of Illinois shall participate in an Emergency Medical Data Collection System developed by the Department for the purpose of fulfilling the requirements of this Act.

b) Forms will be provided by the Department for use in collecting the data without requiring modifications to internal record keeping systems.

c) Annual reports required to be submitted to the Department under Section 535.240 need not include data reports pertaining to the evaluation of patient care, transport or outcomes except as it is desirable to do so to summarize System activity.

d) All agencies making formal application to the Department for EMS System program approval as a Resource, Associate or Participating hospital or facility shall include in their proposal:

1) Identification of data collection methods and personnel who will maintain data.

2) Plans for linking pre-hospital emergency patient records with hospital-related records (and transfer records) which permit tracking of case outcomes while preserving the privacy of the patient. A sample of each form used in the linkage shall be included in the proposal.

e) The evaluation parameters of the Emergency Medical Data Collection System shall assess the Systems' impact on death and disability. Statistical summaries of the results shall be distributed by the Department to participants and the Illinois General Assembly.

f) All information provided to the Department as part of the Emergency Medical Data Collection System is of a confidential character as defined by Part 21 of the Code of Civil Procedure (Ill. Rev. Stat. 1987, ch. 110, pars. 8-2101 et seq.). This Act provides for the confidential character of research, evaluations or other studies conducted by the Illinois Department of Public Health. No patient names will be requested.

g) All agencies should be aware of any applicable State and Federal laws and regulations preserving confidentiality and prohibiting access to records or other identifying information for mental health patients or patients being treated for alcohol or drug abuse.

(Source: Amended at 12 Ill. Reg. 22406, effective December 15, 1988)

SUBPART K: WAIVER PROVISIONS

Section 535.750 Waiver Provisions

a) *The Department may grant a waiver to any provision of this Part for a specified period of the time determined appropriate by the Department when it can be demonstrated that there will be no reduction in standards of medical care* (Section 13.1 of the Act).

b) An application for waiver shall be submitted in writing to the Department, and shall contain the following information:

1) The applicant's name, address, and license number (if applicable),

2) The Section of this Part for which the waiver is being sought,

3) An explanation of why the applicant considers compliance with the Section to be a hardship, including a description of how the applicant has attempted to comply with the Section,

4) The period of time for which the waiver is being sought,

5) An explanation of how the waiver will not reduce the standards of medical care established by the Act and this Part, and

6) If the applicant is a System Participant, the applicant's Project Medical Director shall state in writing whether the PMD recommends or opposes the application for waiver, the PMD's reason for such recommendation or opposition, and the PMD's statement of how the waiver will or will not reduce the standards of medical care established by the Act and this Part. The applicant shall submit the PMD's statements along with the application for waiver.

c) A Project Medical Director may apply to the Department for a waiver on behalf of a System Participant, by submitting an application which contains all of the information required by subsection (b) of this Section, along with a statement signed by the System Participant requesting or authorizing the PMD to make such application.

d) The Department shall review all requests for waivers which contain all of the information required by subsection (b) of this Section.

e) The Department shall grant the requested waiver if it finds that:
   1) The waiver will not reduce the standards of medical care established by the Act and this Part,
   2) Full compliance with the regulation at issue is or would be a hardship on the applicant,
   3) For an EMT seeking a waiver to extend a relicensure date in order to complete relicensure requirements,
      A) The EMT has previously received no more than one (1) extension since his or her last relicensure, and
      B) The EMT has not established a pattern of seeking extensions (e.g., waivers sought based on the same type of hardship in two (2) or more previous license periods),
   4) For an applicant other than an EMT,
      A) The applicant has previously received no more than one (1) waiver of the same regulation during the current license or designation year,
      B) The applicant has not established a pattern of seeking waivers of the same regulation during previous license or designation years, and
      C) Unless the Department finds that the hardship preventing compliance with the particular regulation is of an ongoing nature.
f) When granting a waiver, the Department shall specify the regulation or portion thereof which is being waived, any alternate requirement which the waiver applicant shall meet, and any procedures or timetable which the waiver applicant shall follow in order to achieve compliance with the waived regulation.
g) The Department shall determine the length of any waiver which it grants, based on the nature and extent of the hardship, and the medical needs of the community or areas in which the waiver applicant functions.

(Source: Amended at 17 Ill. Reg. 8196, effective May 21, 1993)

SUBPART L: REGISTERED PROFESSIONAL NURSE (FIELD RN/MICN)

Section 535.800 General Provisions

The Project Medical Director shall submit to the Department, as part of the EMS System Program Plan or as an amendment to an approved System Program Plan, a complete description of the System's requirements for training, testing, approval, renewal of approval and use of Field RNs and MICNs.

(Source: Added at 13 Ill. Reg. 15414, effective September 15, 1989)

Section 535.810 Field RN Training

a) Applications for approval of Field RN Training programs shall be filed with the Department on forms prescribed, prepared and furnished by the Department and similar to those prescribed for EMT-P training programs.
b) Applications for approval shall be submitted at least 30 days in advance of the first scheduled class.
c) The Project Medical Director of the EMS System shall attest that the training program shall include:
   1) A course in extrication training which is based upon the United States Department of Transportation, National Standard Curriculim for EMT- Basic;
   2) A course which is based upon the United States Department of Transportation, National Standard Curriculum for EMT-Paramedic, Division 1, Pre-Hospital Environment, Sections 1 through 7;
   3) The American Heart Association Advanced Cardiac Life Support (ACLS) course or a course in dysrhythmia identification, therapeutic modalities, pharmacokinetics, intubation, defibrillation and management of cardiac resuscitation that is based upon the ACLS course;
   4) A pre-hospital trauma course, which shall be *either trauma nurse specialist* or *nurse trauma life support or their equivalents as approved by the Project Medical Director* (Section 4.21 of the Act); and
   5) Completion of the necessary field experience required by the program as approved by the Department on a State-approved EMS System vehicle supervised by a licensed EMT-P with a minimum of one year's experience, a Field RN with a minimum of one year's field experience, or a physician with critical care knowledge and experience on an EMS vehicle.

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

Section 535.820 Field RN Testing

Upon completion of training, the Field RN shall be required to pass both didactic and practical examinations, if such examinations are required for EMT-Ps within the System. The Field RN examinations shall cover the Field RN training components and be otherwise equivalent to the EMT-P examinations.

(Source: Added at 13 Ill. Reg. 15414, effective September 15, 1989)

Section 535.830 Field RN Approval

a) To be approved as a Field RN by the Project Medical Director of the EMS System, an applicant shall be a registered nurse, licensed under the "Illinois Nursing Act", and shall have successfully met the requirements of Sections 535.810 and 535.820 of this Part.
b) The approval shall be for a period of two years.

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c) The Project Medical Director shall sign and issue to the approved applicant a Field RN card. The card shall be developed by the Department and provided to the Project Medical Directors.
d) All Project Medical Directors shall submit the names of approved Field RNs to the Department and shall inform the Department of any changes in the status of approved Field RNs.

(Source: Added at 13 Ill. Reg. 15414, effective September 15, 1989)

Section 535.840 Field RN Renewal

Field RN approval shall be renewed by the Project Medical Director upon successful completion of forty (40) hours of continuing education in each of the previous two years (80 hours total), the content of which shall be consistent with the System's continuing education requirements for EMT-Ps and a current CPR certificate which covers:

a) Adult one-rescuer CPR
b) Adult foreign body airway obstruction management
c) Pediatric one-rescuer CPR
d) Pediatric foreign body airway obstruction management
e) Adult two-rescuer CPR
f) Pediatric two-rescuer CPR

(Source: Added at 13 Ill. Reg. 15414, effective September 15, 1989)

Section 535.850 MICN Training

MICN training shall include successful completion of the following:

a) A course in telemetry and communications training which is based upon the United States Department of Transportation, National Standard Curriculum for EMT-Paramedic,
b) The American Heart Association Advanced Cardiac Life Support (ACLS) course or a course in dysrhythmia identification, therapeutic modalities, pharmacokinetics, intubation, defibrillation and management of cardiac resuscitation which is based upon the ACLS course,
c) A pre-hospital trauma support course as approved by the Department, and
d) Other training as required by the Project Medical Director, which may include completion of field experience, as approved by the Department on a State-approved EMS System vehicle supervised by a licensed EMT-P or Field RN with a minimum of one year's field experience or a physician with critical care knowledge and experience on an EMS vehicle.

(Source: Amended at 18 Ill. Reg. 14375, effective September 10, 1994)

Section 535.860 MICN Approval

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a) To be approved as a MICN by the Project Medical Director of the EMS System, an applicant shall be a registered nurse, licensed under the Illinois Nursing Act, and shall have successfully met the requirements of Section 535.850 of this Part.
b) All Project Medical Directors shall submit the names of approved MICNs to the Department and shall inform the Department of any changes in the status of approved MICNs.
c) The Project Medical Director may require approved MICNs to complete continuing education in order to maintain their approved status in the System. Such continuing education may include the performance of clinical skills under the conditions described for field experience in Section 535.850(a) of this Part.

(Source: Amended at 18 Ill. Reg. 14375, effective September 10, 1994)

Section 535.870 Reciprocity

The Project Medical Director may develop and implement, as part of the EMS System Plan, a reciprocity policy for Field RNs and/or MICNs who have been approved by other EMS Systems.

(Source: Added at 13 Ill. Reg. 15414, effective September 15, 1989)

SUBPART M: CERTIFICATION OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section 535.900 Certification of SEMSV Programs - General

a) No person, either as owner, agent, or otherwise shall furnish, operate, conduct, maintain, advertise, or otherwise be engaged in the provision of emergency medical care or transportation to a sick or injured patient using a Specialized Emergency Medical Services Vehicle (SEMSV), unless currently certified by the Department pursuant to this Subpart, or the SEMSV is owned, operated, licensed or regulated by a unit of local government.
b) An application for certification shall be filed with the Department by submitting a Program Plan which includes the information required in this Part. The Program Plan shall be signed by the SEMSV Medical Director and the Project Medical Director of the EMS System of which the SEMSV Program is a part (See Section 535.920(a) of this Part).
c) Each certification shall be valid for a period of one (1) year from the date of issuance, unless suspended or revoked.
d) Each certification shall be issued to the program named in the application for the specific vehicle(s) identified in the application, and shall not be assignable or transferable.
e) An application for renewal of certification shall be filed with the Department at least thirty (30) days prior to the expiration date, on a form prepared and furnished by the Department. The renewal

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application shall be accompanied by photocopies of any current licenses or certificates required of SEMSV personnel by the provisions of this Part (See Sections 535.920(e), 535.931, 535.932(a) of this Part), and verification that SEMSV personnel continuing education required by the provisions of this Part have been met (See Section 535.930(d) of this Part). Each renewed certificate shall be valid for a period of one (1) year from the date of issuance, unless suspended or revoked.

f) The Department shall inspect any vehicles, equipment, records or other documents covered by the certified or applicant SEMSV program annually to determine initial or continued compliance with the requirements of the Act or this Part.

(Source: Amended at 14 Ill. Reg. 15390, effective September 1, 1990)

Section 535.910 Denial, Nonrenewal, Suspension or Revocation of Certification

a) The Department, after notice and an opportunity for hearing, shall deny an application for certification or renewal, suspend, or revoke a certification when the applicant or certificate holder has failed to meet or has violated any of the requirements of the Act or this Part, or any SEMSV personnel, during the provision of emergency services, engaged in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public, such as not meeting the requirements of this Act, charging for services or equipment not provided or used, or utilizing unqualified personnel or as provided in Section 535.650(a)(4).

b) All hearings shall be governed by the Department's Rules of Practice and Procedures for Administrative Hearings (77 Ill. Adm. Code 100). Upon receipt of a notice to deny, nonrenew, suspend or revoke, the applicant or certificate holder shall have ten (10) business days in which to request such a hearing.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.920 SEMSV Program Certification Requirements for All Vehicles

a) The SEMSV program shall be part of a Department-approved EMS System.

b) The SEMSV program shall meet and comply with all State and Federal requirements governing the specific vehicles employed in the program (See Sections 535.933, or 535.941, or 535.951 of this Part).

c) The SEMSV program shall comply with this Part during its hours of operation. The SEMSV program shall operate twenty-four (24) hours per day, every day of the year in accordance with weather conditions except when the service is committed to another medical emergency request, or is unavailable due to maintenance requirements.

d) The SEMSV program shall provide pre-hospital emergency services within its service area on a per need basis without regard to the patient's ability to pay for such service. (See Section 535.150(g)(2)).

e) The SEMSV program shall be supervised and managed by a Medical Director, who shall be a physician who has met at least the following requirements:

1) One or more of the following:
   A) Board certification by the American Board of Emergency Medicine,
   B) Completion of twelve (12) months of internship, followed by sixty (60) months plus seven thousand (7000) hours of hospital based Emergency Medical (two thousand eight hundred (2800) of the seven thousand (7000) hours must be completed within one twenty-four (24) month period), and document fifty (50) hours of continuing medical education in Emergency Medicine for each complete year of practice,
   C) Completion of residency in Emergency Medicine as defined in 77 Ill. Adm. Code 540.20, in a residency program approved by the Residency Review Committee for Emergency Medicine,
   D) Board certified or prepared in Internal Medicine,
   E) Board certified or prepared in General Surgery.
2) Training and experience in Advanced Cardiac Life Support (ACLS), such as the American Heart Association's ACLS course,
3) Training and experience in Advanced Trauma Life Support (ATLS), such as the American College of Surgeons' ATLS course,
4) In programs utilizing air vehicles documentation, such as certificates of completion in course work designed to bring about:
   A) Experience and knowledge in inflight treatment modalities,
   B) Experience and knowledge in altitude physiology,
   C) Experience and knowledge in infection control as it relates to airborne and intra facility transportation, and
   D) Experience and knowledge in stress management techniques.
5) In programs utilizing watercraft documentation, such as certificates of completion in course work designed to bring about:
   A) Experience and knowledge in drowning (cold, warm, fresh, and salt water), and
   B) Experience and knowledge in diving accident physiology and treatment.

(Source: Amended at 14 Ill. Reg. 15390, effective September 1, 1990)

Section 535.930 Helicopter and Fixed-Wing Aircraft Requirements

In addition to the requirements specified in Sections 535.900 and 535.920 of this Part, a SEMSV Program utilizing helicopters or fixed-wing aircraft shall submit a Program Plan which includes the following:

a) Documentation of the Medical Director's credentials as required by Section 535.920(e) of this Part, and a statement signed by the Medical

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Director containing his or her commitment to the following duties and responsibilities:

1) The supervision and management of the program,
2) Supervising and evaluating the quality of patient care provided by the aeromedical crew,
3) Developing written treatment protocols and standard operating procedures to be used by the aeromedical crew during flight,
4) Developing and approving a list of equipment and drugs to be available on the SEMSV during patient transfer,
5) Providing periodic review, at least monthly, of patient care provided by the aeromedical crew,
6) Providing for the continuing education of the aeromedical team,
7) Providing medical advice/expertise on the utilization, need, and special requirements of aeromedical transfer,
8) Submit documentation assuring the qualifications of the aeromedical crew,
9) Notifying the Department when the primary SEMSV is unavailable in excess of 24 hours, stating the reason for unavailability, the expected date of return to service, and the provisions made, if any, for replacement vehicles, and
10) Assuring appropriate staffing of the SEMSV, with a minimum of one (1) EMS pilot and one (1) aeromedical crew member. Two (2) EMS pilots shall be used for fixed-wing aircraft or helicopters requiring such staffing. Additional aeromedical personnel may be required at the discretion of the SEMSV Medical Director. The Medical Director shall provide the Department with a list of all approved pilots and aeromedical crew members, and shall update the list whenever a change in such personnel is made.

b) The SEMSV Medical Director's list of required medical equipment and drugs for use on the aircraft (See Section 535.934),
c) The SEMSV Medical Director's treatment protocols and standard operating procedures.
d) The curriculum and requirements for orientation and training, including mandatory continuing education for all aeromedical crewmembers consisting of at least sixteen (16) hours in specialized aeromedical transportation topics, eight (8) hours of which may include quality assurance reviews,
e) A description of the communications system accessing the aeromedical dispatch center, the medical control point, receiving and referring agencies (See 535.936 of this Part),
f) A description and map of the service area for each vehicle,
g) A description of the EMS System's method of providing emergency medical services utilizing the SEMSV Program,
h) The identification number and description of all vehicles used in the program.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

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Section 535.931 EMS Pilot Specifications

a) EMS Pilot approval for helicopters and fixed-wing aircraft shall be valid for a period of one year and may be renewed by the Medical Director if the pilot has completed renewal training, which shall include but is not limited to the requirements of subsections 535.931(b)(1) and (5)(A) through (H) or subsection (c)(1) and (3)(A) through (F) of this Section.
   1) For helicopter programs only:
      A) Three (3) EMS pilots per helicopter, excluding relief support, shall be dedicated to the SEMSV program.
      B) An EMS pilot assigned to SEMSV duty shall be physically present at the aircraft base in order to assure timely response.
      C) An EMS pilot assigned to SEMSV duty shall be provided with work space to carry out assigned duties. In the event that duty time exceeds twelve (12) continuous hours, separate sleeping quarters shall be provided to assure physical rest.
   2) For fixed-wing programs only:
      One EMS pilot per aircraft who will respond within one-half (1/2) hour from the receipt of the request.
b) Each EMS Pilot assigned to a helicopter shall be approved by the Medical Director and shall meet the following requirements:
   1) Compliance with subparts E and F of Air Taxi Operations and Commercial Operators (14 CFR 135),
   2) A minimum of two thousand (2000) rotorcraft flight hours as pilot-in-command, twenty-five (25) hours of which shall be in the type of aircraft utilized in the SEMSV program,
   3) A minimum of five (5) hours day/night area flight orientation and, in the judgement of the SEMSV Medical Director, special terrain flight orientation,
   4) Instrument Flight Rules (IFR) certification by the Federal Aviation Administration (IFR Currency is recommended),
   5) Documentation of completion of training which includes but is not limited to the following:
      A) Judgment and decision making,
      B) Local routine operating procedures, including day and night operations,
      C) Flight by reference to instruments, including Instrument Meteorological Conditions (IMC) recovery,
      D) Regional area weather phenomena,
      E) Area terrain hazards,
      F) Scene procedures.
      G) EMS System and SEMSV Program communications requirements,
      H) Orientation to each hospital/pre-hospital health care system affiliated with the SEMSV Program.
c) Each pilot assigned to a fixed-wing aircraft shall be approved by the Medical Director and shall meet the following requirements:

1) Compliance with subparts E and F of Air Taxi Operations and Commercial Operators (14 CFR 135),
2) The pilot shall have a commercial pilot certificate with a minimum of two thousand (2000) flight hours as pilot-in-command and an airplane multi-engine land instrument rating, with a minimum of two hundred fifty (250) hours of instrument flying time, to include no more than one hundred twenty five (125) hours of simulated time and one hundred (100) night flight hours,
3) Documentation of completion of training which includes but is not limited to the following:
   A) Judgment and decision making,
   B) Local routine operating procedures, including day and night operations,
   C) Flight by reference to instruments, including Instrument Meteorological Conditions (IMC) recovery,
   D) Regional area weather phenomena,
   E) Area terrain hazards,
   F) EMS System and SEMSV Program communications requirements.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.932 Aeromedical Crew Member Training Requirements

a) Except as provided for by subsection (b) of this Section, each aeromedical crew member assigned to a helicopter or fixed-wing aircraft shall be approved by the Medical Director and shall meet the following requirements:
   1) Be an EMT-P, registered nurse or a physician licensed to practice medicine in all of its branches,
   2) Documentation of completion of training which includes but is not limited to the following:
      A) Advanced life support,
      B) Cardiac emergencies,
      C) Traumatic emergencies,
      D) Pediatric emergencies,
      E) Obstetrical emergencies,
      F) Neonatal emergencies,
      G) Psychiatric emergencies,
      H) Crisis intervention,
      I) Infection control,
      J) Altitude physiology,
      K) Advanced surgical and airway management techniques,
      L) Environmental emergencies,
      M) Flight safety,
      N) Aircraft emergencies,
      O) Radio communications,
      P) Rescue and survival techniques,
      Q) Record keeping,

      R) Legal aspects.
   3) Yearly completion of the continuing education requirements as described in Section 535.930 (d) of this Part.
b) In addition to at least one (1) aeromedical crew member who has met the requirements of subsection (a) of this Section, the Medical Director may approve and assign additional crew members to a helicopter or fixed-wing aircraft. Such additional crew members shall meet the following requirements:
   1) Documentation of completion of training which includes but is not limited to the following:
      A) General patient care in-flight,
      B) Aircraft emergencies,
      C) Flight safety,
      D) EMS System and SEMSV Program communications,
      E) Use of all patient care equipment, and
      F) Rescue and survival techniques.
   2) Yearly completion of the continuing education requirements as described in Section 535.930 (d) of this Part.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.933 Aircraft Vehicle Specifications and Operation

a) All vehicles shall meet the requirements of subparts A, B, C, and D of Air Taxi Operations and Commercial Operators (14 CFR 135).
b) All vehicles shall have communication equipment to permit both internal crew and air-to-ground exchange of information between individuals and agencies, including at least those involved in SEMSV medical control within the EMS System, the flight operations center, air traffic control, and law enforcement agencies.
c) All vehicles shall be designed to allow the loading and unloading of the patient without rotating the patient more than thirty (30) degrees along the longitudinal axis or forty-five (45) degrees along the lateral axis.
d) All vehicles shall be climate controlled to prevent temperature extremes that would adversely affect patient care in the judgement of the Medical Director.
e) All vehicles shall have interior lighting, to permit patient care to be given and patient status to be monitored without interfering with the pilot's vision.
f) All vehicles shall carry survival equipment including but not limited to:
   1) Two (2) sources of heat or fire,
   2) Two (2) forms of signaling device,
   3) Equipment to provide shelter, blanket, nylon cord, adhesive tape,
   4) Knife and fishing kit, and
   5) Food and water supply.
g) All patients shall be restrained to the helicopter or fixed-wing

aircraft litter in order to assure the safety of the patient and crew.

h) For helicopter programs:
   1) There shall be at least one (1) single-engine aircraft.
   2) Each vehicle shall be staffed with at least one (1) EMS pilot and at least one (1) aeromedical crew member.
   3) Each vehicle shall be equipped with flight reference instruments to allow recovery from inadvertent IFR situations.
   4) Each vehicle shall be equipped with a searchlight pivoting at least one hundred eighty (180) degrees horizontal and ninety (90) degrees vertical, controlled by the pilot without removing hands from the flight controls.
   5) The cockpit shall be isolated, by a protective barrier, to minimize inflight distraction or interference.
   6) All medical equipment, supplies and personnel shall be secured and/or restrained.

i) For fixed-wing aircraft programs:
   1) There shall be at least one (1) twin-engine aircraft.
   2) Each vehicle shall be staffed with at least one (1) EMS pilot, and at least one (1) aeromedical crew member.
   3) The aircraft shall be Instrument Flight Rules (IFR) equipped and certified.
   4) All equipment, litters/stretchers and seating shall be arranged so as not to block rapid egress by personnel or patient from the aircraft and affixed or secured in approved racks, compartments or by strap restraint.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.934 Aircraft Medical Equipment and Drugs

a) Each helicopter or fixed-wing aircraft shall be equipped with medical equipment and drugs which are appropriate for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.

b) The following list of supplies shall be available for each mission but may not be utilized on each mission. The SEMSV Medical Director shall decide what medical equipment and drugs from the list will be taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route. Additional equipment not listed in the rules may be utilized at the discretion of the SEMSV Medical Director.
   1) Cardiac monitor and defibrillator with adult and pediatric paddles and appropriate accessories,
   2) Oxygen masks in adult, child and infant sizes,
   3) Oxygen valve key,
   4) Oxygen connective/extension tubing,
   5) Nasal cannulas, medium and small,

   6) Non-rebreathing mask,
   7) Oxygen regulator,
   8) Oxygen flowmeter, capable of providing 1 thru 15 l/min. flow,
   9) Oxygen outlet or tank, size E or H,
   10) Endotracheal tubes, sizes 5, 6, 7, 8, cuffed, and 2, 3, 4 uncuffed
   11) Magill forceps,
   12) Laryngoscope, with adult, child and infant blades, both curved and straight,
   13) Bag-valve-mask with a reservoir system,
   14) Portable suction device, able to provide a vacuum of 300 mm Hg through a shatterproof catchment container for a minimum of twenty minutes,
   15) Suction outlet,
   16) Set of oropharyngeal/nasopharyngeal airways for adults, children and infants,
   17) Suction catheters, flexible, set of sizes 6fr, 14fr and 18fr,
   18) Suction catheter, rigid,
   19) Suction connective tubing,
   20) Suction rinsing bottle, shatterproof,
   21) Burn sheets,
   22) Trauma dressings, sterile,
   23) 4x4 sterile dressings,
   24) Tape, adhesive, 1" rolls,
   25) Tape, paper, adhesive, 1"rolls,
   26) Bandage, gauze, roller soft sterile 2x4" rolls,
   27) Bandage, elastic, 2x6", non-sterile rolls,
   28) Alcohol preps, disposable,
   29) Providone Iodine,
   30) Sterile petroleum gauze dressing,
   31) Gloves, latex,
   32) Eye patches, sterile,
   33) Air-sick bags,
   34) Cutting snears with protective tip,
   35) Board, spinal immobilization device, long,
   36) Traction splint,
   37) Cervical collar, rigid, adult and child,
   38) Lateral cervical stabilization devices,
   39) Stethoscope with bell and diaphragm,
   40) Blood pressure cuffs, adult and pediatric,
   41) Sphygmomanometer,
   42) Childbirth kit, emergency, disposable, sterile,
   43) Flashlight,
   44) Blanket,
   45) Sheet, non-sterile,
   46) Sheet, sterile,
   47) Pneumatic counterpressure trouser kit, adult and child,
   48) Catheter over needle sets, indwelling IV, 14, 16, 18, 20, 22

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guage, each,
49) Needles, 18, 20 guage each,
50) Syringe, tuberculin, 1 cc.,
51) Syringes, 3, 10, 20, 35, cc., each,
52) Dextrose, 5% in water,
53) Dextrose, 5%, 1/4 Normal Saline,
54) Lactated ringers solution, 1000cc.,
55) Normal Saline, 1000cc.,
56) Water, sterile, for injection,
57) Intravenous administration set, minidrip,
58) Intravenous administration set, standard,
59) IV infusion pump,
60) Pressure Infusor,
61) Atropine sulfate, 1mg. ampules,
62) Dextrose, 50%, 25gm ampules,
63) Epinephrine, 1mg, 1:10,000 ampules,
64) Epinephrine, 1mg, 1:1000 ampules,
65) Naloxone, 2mg, ampules,
66) Nitroglycerin sublingual tablets, 1/150 grain,
67) Sodium Bicarbonate, 50 mEq ampules.
68) Lidocaine HCL 100 mgm/5cc,
69) Lidocaine HCL 1 Gm vial or premix solution of 4 mgm/ml.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.935 Vehicle Maintenance

a) For helicopter programs:
   1) The maintenance program shall meet the requirements of subpart J of Air Taxi Operations and Commercial Operators (14 CFR 135).
   2) One (1) certified A & P (airframe and power plant) mechanic with two (2) years experience for each helicopter shall be available and dedicated to the program twenty-four (24) hours per day.
   3) Mechanics shall have completed factory-provided training for the makes and models of aircraft utilized in the SEMSV program.
   4) Back-up maintenance support shall be available when the primary mechanic is unavailable or during times of extensive maintenance needs.
   5) Hangar facilities shall be available for major maintenance activities, as specified in manufacturer's requirements. These facilities need not be located at the base of operations.
   6) Progressive maintenance on aircraft utilized by the SEMSV program is recommended, including routine daily inspections, as required by the aircraft manufacturer.
b) For fixed-wing aircraft programs:
   1) The maintenance program shall meet the requirements of subpart J of Air Taxi Operations and Commercial Operators (14 CFR 135).
   2) Mechanics shall be certified A & P (airframe and power plant)

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with two (2) years experience, and shall have completed training for the make and model of aircraft utilized by the SEMSV Program.
   3) Hangar facilities shall be available for major maintenance activities as specified in manufacturer's requirements.
   4) Progressive maintenance on aircraft utilized by the SEMSV program is recommended, including routine daily inspections, as required by the aircraft manufacturer.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.936 Aircraft Communications and Dispatch Center

a) The SEMSV program shall have a designated person assigned and available twenty-four (24) hours per day every day of the year to receive and dispatch all requests for aeromedical services. For fixed-wing aircraft programs, a telephone answering service may be used.
b) The dispatch center shall have at least one dedicated telephone number for the SEMSV program.
c) A pre-arranged emergency plan shall be in place to cover situations in which an aircraft is overdue, radio communication cannot be established, or an aircraft location cannot be verified.
d) A back-up power source shall be available for all communications equipment utilized at the SEMSV medical control point.
e) In addition, for helicopter programs:
   1) The dispatch center shall have the capability to communicate with the aircraft pilot and aeromedical crew for non-medical purposes on a separate designated frequency.
   2) Continuous flight following every fifteen minutes shall be maintained and documented.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.940 Watercraft Requirements

In addition to the requirements specified in Sections 535.900 and 535.920 of this Part, a SEMSV Program utilizing watercraft shall submit a program plan which includes the following:

a) Documentation of the Medical Director's credentials as required by Section 535.920(e) of this Part, and a statement signed by the Medical Director containing his or her commitment to the following duties and responsibilities:
   1) The supervision and management of the program,
   2) Supervising and evaluating the quality of patient care provided by the watercraft crew.
   3) Developing written treatment protocols and standard operating procedures to be used by the watercraft crew during vehicle operation,

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4) Developing and approving a list of equipment and drugs to be available on the SEMSV during patient transfer,
5) Providing periodic review, at least quarterly, of patient care provided by the watercraft crew,
6) Providing medical advice/expertise on the utilization, need, and special requirements of watercraft transfer,
7) Submit documentation assuring the qualifications of the watercraft crew,
8) Assuring appropriate staffing of the SEMSV:
   A) Each watercraft crew member assigned to a watercraft shall be approved by the Medical Director, who shall provide the Department with a list of all approved crew members and watercraft operators and update the list whenever a change in such personnel is made.
   B) For Advanced Life Support (ALS) operations, the watercraft shall be staffed by a crew of at least one (1) EMT-P, registered nurse or physician, and one (1) other EMT, registered nurse or physician, in addition to the watercraft operator.
   C) For Basic Life Support (BLS) operations, the watercraft shall be staffed by a crew of at least two (2) EMTs, registered nurse or pnysicians, one (1) of whom may also be the watercraft operator.
   D) Except as provided for by subsection (a)(8)(E) of this Section, each watercraft crew member shall document the completion of training which includes but is not limited to the following:
      i) Advanced life support,
      ii) Cardiac support,
      iii) Traumatic emergencies,
      iv) Pediatric emergencies,
      v) Psychiatric emergencies,
      vi) Crisis intervention,
      vii) Infection control,
      viii) Advanced surgical and airway management techniques,
      ix) Environmental emergencies,
      x) Radio communications,
      xi) Rescue and survival techniques,
      xii) Record keeping,
      xiii) Legal aspects,
      xiv) Certification in Advanced Life Saving by the American Red Cross,
      xv) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act (Ill. Rev. Stat. 1987, ch. 95 1/2, par. 315-13).
   E) In addition to at least two (2) watercraft crew members who have met the requirements of subsections (a)(8)(B) through (D) of this Section, the Medical Director may approve and assign additional watercraft crew members to a watercraft. Such additional watercraft crew members shall document the completion of training which includes but is not limited to the following:
      i) General patient care,
      ii) Watercraft emergencies,
      iii) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act (Ill. Rev. Stat. 1987, ch. 95 1/2, par. 315-13),
      iv) EMS System and SEMSV Program communications,
      v) Use of all patient care equipment,
      vi) Rescue and survival techniques,
      vii) Certification in Advanced Life Saving by the American Red Cross.
   F) Watercraft operators shall be at least twenty-one (21) years of age, and shall meet the following requirements:
      i) Certification in Advanced Life Saving by the American Red Cross,
      ii) Completion of a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act (Ill. Rev. Stat. 1987, ch. 95 1/2, par. 315-13).
b) The SEMSV Medical Director's list of required medical equipment and drugs for use on the watercraft (See Section 535.942),
c) The SEMSV Medical Director's standing orders (treatment protocols, standard operating procedures),
d) A description of the communications system linking the watercraft with the SEMSV medical control point,
e) A description of the EMS System's method of providing emergency medical services utilizing the SEMSV Program,
f) A description and map of the service area for each vehicle,
g) The identification number and description of all vehicles used in the program.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.941 Watercraft Vehicle Specifications and Operation

a) All watercraft shall meet the requirements of Article IV of the Boat Registration and Safety Act (Ill. Rev. Stat. 1987, ch. 95 1/2, pars. 314-1 through 314-10).
b) All watercraft shall carry equipment including but not limited to the following:
   1) One (1) anchor with line attached that is three times the maximum depth of water in the areas of usual operation,
   2) Two (2) docking fenders,
   3) Two (2) mooring lines,
   4) Self or mechanical bailer,
   5) Search light with a minimum of two hundred thousand (200,000)

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candle power,
6) Swim harness attached to seventy-five (75) feet of tethering line,
7) Waterproof flashlight, six volt minimum,
8) Basic tool kit, to include at least:
A) Wrench, twelve (12) inch with adjustable open end,
B) Screw driver, twelve (12) inch with straight blade,
C) Locking pliers, minimum length, ten (10) inches,
9) One (1) life jacket for each member of the watercraft crew and two (2) extra adult life jackets,
10) Two (2) child life jackets,
11) Knife, six (6) inch blade, with sheath,
12) Boat hook, extendable to at least ten (10) feet,
13) A locking mechanism to secure a stretcher or litter below the gunwhale level,
14) For watercraft operating on Lake Michigan:
A) A UHF FM marine radio with at least twenty-five (25) watts of power,
B) Loran Navigational Aid,
C) Navigational charts for service area and navigational aids, including compass,
D) Speed capability of twenty (20) knots per hour.

c) All watercraft shall have communication equipment to assure exchange of information between individuals and agencies, including at least those involved at the SEMSV medical control point within the EMS System, and law enforcement agencies.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.942 Watercraft Medical Equipment and Drugs

a) Each watercraft shall be equipped with medical equipment and drugs which are appropriate for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.

b) For Advanced Life Support (ALS) operations, the following list of supplies shall be available for each mission but may not be utilized on each mission. The SEMSV Medical Director shall decide what medical equipment and drugs from the list will be taken on any particular mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route. Additional equipment not listed in the rules may be utilized at the discretion of the SEMSV Medical Director.
1) One (1) two-way radio for voice and electrocardiogram transmission communication between the watercraft and the SEMSV medical control point,
2) Cardiac monitor and defibrillator with adult and pediatric paddles and appropriate accessories,
3) Oxygen masks in adult, child and infant sizes,

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4) Oxygen valve key,
5) Oxygen connective extention tubing,
6) Nasal cannulas, medium and small,
7) Non-rebreathing mask,
8) Oxygen regulator,
9) Oxygen flowmeter, capable of providing 1 thru 15 l/min flow,
10) Oxygen cutlet or tank, size D, E or H,
11) Bag-valve-mask with a reservoir system,
12) Portable suction device, able to provide a vacuum of 300 mm Hg through a shatterproof catchment container for a minimum of twenty minutes,
13) Set of oropharyngeal/nasopharyngeal airways for adults, children and infants,
14) Suction catheters, flexible, set of sizes 5fr, 14fr and 18fr,
15) Suction catheter, rigid,
16) Suction connective tubing,
17) Suction rinsing bottle, shatterproof,
18) Trauma dressings, sterile,
19) 4x4 sterile dressings,
20) Tape, adhesive, 2" rolls,
21) Tape, paper, adhesive, 2" rolls,
22) Bandage, gauze, roller soft sterile 2x4" rolls,
23) Bandage, elastic 1x6", non-sterile rolls,
24) Alcohol preps, disposable,
25) Povidine iodine,
26) Sterile petroleum gauze dressing,
27) Gloves, latex,
28) Eye patches, sterile,
29) Cutting shears with protective tip,
30) Board, long spine with three straps, compatible with basket litter,
31) Traction splint,
32) Pulse-able cervical immobilization device, adult and child, with reflective material,
33) Basket litter with dimension device which shall automatically float the patient head and face up,
34) Stethoscope with bell and diaphragm,
35) Blood pressure cuffs, adult and pediatric
36) Sphygmomanometer,
37) Blanket,
38) Sheet, non-sterile,
39) Pneumatic counterpressure trouser kit, adult and child,
40) Catheter over needle sets, indwelling 17, 14, 16, 18, 20, 22 gauge, each,
41) Needles, 18, 20 gauge each,
42) Syringe, tuberculin, 1 cc.,
43) Syringes, 3, 10, 20, 35 cc., each,
44) Dextrose, 5% in water,

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45) Lactated Ringers solution, 1000cc.,
46) Intravenous administration set, minidrip,
47) Intravenous administration set, standard,
48) Atropine sulfate, 1mg, ampules,
49) Dextrose, 50%, 50gm ampules,
50) Epinephrine, 1mg, 1:1000 ampules,
51) Epinephrine, 1mg, 1:10000 ampules,
52) Naloxone, 1mg, ampules,
53) Nitroglycerin sublingual, tablets, 1:150 grain,
54) Sodium Bicarbonate, 8.4%Eq ampules,
55) Lidocaine HCL 100 mgm vial,
56) Lidocaine HCL 1.5% vial or premix solution of 4 mgm/ml.

c) For Basic Life Support (BLS) operations, these supplies shall include, but need not be limited to:
1) A VHF radio capable of providing voice communication between the watercraft and appropriate EMS agencies.
2) The supplies listed in subsections b)(3) through (40) of this Section.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.943 Watercraft Communications and Dispatch Center

a) The SEMSV program shall have a designated dispatch center assigned and available twenty-four (24) hours per day every day of the year to receive and dispatch all requests for watercraft services.
b) The communications and dispatch center shall have the ability to communicate with the watercraft for non-medical purposes on a separate designated frequency.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.950 Off-Road SEMSV Requirements

In addition to the requirements specified in Sections 535.900 and 535.920 of this Part, a SEMSV Program utilizing off-road SEMS vehicles shall submit a Program Plan which includes the following:

a) Documentation of the Medical Director's credentials as required by Section 535.920 e) of this Part, and a statement signed by the Medical Director containing his or her commitment to the following duties and responsibilities:
1) The supervision and management of the program,
2) Supervising and evaluating the quality of patient care provided by the off-road SEMSV crew,
3) Developing written standing orders, treatment protocols, Standard Operating Procedures to be used by the off-road SEMSV crew during vehicle operation,
4) Developing and approving a list of equipment and drugs to be available on the off-road SEMSV during patient transfer,
5) Providing medical advice expertise on the utilization, need, and special requirements of off-road SEMSV transfer,
6) Submit documentation assuring the qualifications of the off-road SEMSV crew,
7) Assuring appropriate staffing of the off-road SEMS vehicle:
A) For Advanced Life Support (ALS) operations, the vehicle shall be staffed by a minimum of one (1) EMT-P, registered nurse or physician and one (1) other EMT, registered nurse or physician, one of whom may also be the driver of the off-road SEMS vehicle.
B) For Basic Life Support (BLS) operations, the vehicle shall be staffed by a minimum of two 2) EMTs, registered nurses or physicians, one of whom may also be the driver of the off-road SEMS vehicle.
b) The SEMSV Medical Director's list of required medical equipment and drugs for use on the off-road SEMSV. See Section 535.952).
c) The SEMSV Medical Director's standing orders (treatment protocols, standard operating procedures).
d) A description of the communications system linking the off-road SEMSV with the SEMSV medical control point.
e) A description and map of the service area for each vehicle.
f) The identification number and description of all vehicles used in the program.
g) A description of the EMS System's method of providing emergency medical services utilizing the SEMSV Program.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.951 Off-Road Vehicle Specifications and Operation

a) The off-road SEMSV shall have sufficient space for the vehicle operator, a patient in a supine position, and paramedal rendering medical care along side of the patient.
b) Each vehicle shall have a locking mechanism to secure the litter stretcher or backboard to the off-road SEMSV.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.952 Off-Road Medical Equipment and Drugs

a) Each off-road SEMSV shall be equipped with medical equipment and drugs for the various types of missions to which it will be responding, as specified by the SEMSV Medical Director.
b) For Advanced Life Support (ALS) operations, the following list of supplies shall be available for each mission but may not be utilized on each mission. The SEMSV Medical Director shall decide what medical equipment and drugs from the list will be taken on any particular

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mission based on patient type (adult, child, infant), medical condition (high risk infant, cardiac, burn, etc.) and anticipated treatment needs en route. Additional equipment not listed in the rules may be utilized at the discretion of the EEMSV Medical Director.

1) One (1) telemetry radio for voice and electrocardiogram transmission communication between the off-road EEMSV and the EEMSV medical control point,
2) Cardiac monitor and defibrillator with adult and pediatric paddles and appropriate accessories,
3) Oxygen masks in adult, child and infant sizes,
4) Oxygen valve key,
5) Oxygen connective extention tubing,
6) Nasal cannulas, medium and small,
7) Non-rebreathing mask,
8) Oxygen regulator,
9) Oxygen flowmeter, capable of providing 1 thru 15 l/min flow,
10) Oxygen outlet or tank, size D, E or H,
11) Bag-valve-mask with a reservoir system,
12) Portable suction device, able to provide a vacuum of 300 mm Hg through a shatterproof containment container for a minimum of twenty minutes,
13) Set of oropharyngeal nasopharyngeal airways for adults, children and infants,
14) Suction catheters, flexible, set of sizes 6fr, 14fr and 18fr,
15) Suction catheter, rigid,
16) Suction connective tubing,
17) Suction rinsing bottle, shatterproof,
18) Trauma dressings, sterile,
19) 4x4 sterile dressings,
20) Tape, adhesive, 2" rolls,
21) Tape, paper, adhesive, 1" rolls
22) Bandage, gauze, roller soft sterile 2x4" rolls,
23) Bandage, elastic, 2x6", non-sterile rolls,
24) Alcohol preps, disposeable,
25) Providine Iodine,
26) Sterile petrileum gauze dressing,
27) Gloves, latex,
28) Eye patches, sterile,
29) Cutting shears with protective tip,
30) Board, long spine with three straps, compatible with basket litter,
31) Traction splint,
32) Stethoscope with bell and diaphragm,
33) Blood pressure cuffs, adult and pediatric,
34) Sphygmomanometer,
35) Blanket,
36) Sheet, non-sterile,
37) Pneumatic counterpressure trouser kit, adult and child,

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38) Catheter over needle sets, indwelling IV, 14, 16, 18, 20, 22 gauge, each,
39) Needles, 18, 20 gauge each,
40) Syringe, tuberculin, 1 cc.,
41) Syringes, 3, 10, 20, 35, cc., each,
42) Dextrose, 5% in water,
43) Lactated ringers solution, 1000cc.,
44) Intravenous administration set, minidrip,
45) Intravenous administration set, standard,
46) Atropine sulfate, 1mg, ampules,
47) Dextrose, 50%, 25gm ampules,
48) Epinephrine, 1mg, 1:1,000 ampules,
49) Epinephrine, 1mg, 1:10,000 ampules,
50) Naloxone, 2mg, ampules,
51) Nitroglycerin sublingual tablets, 1/150 grain,
52) Sodium Bicarbonate, 50 mEq ampules,
53) Lidocaine HCL 100 mgm/5cc,
54) Lidocaine HCL 1 gm vial or premix solution of 4 mgm/ml.

c) For Basic Life Support (BLS) operations, these supplies shall include, but need not be limited to:
   1) Radio communication equipment which will provide voice contact with personnel who can access EMS agencies,
   2) The supplies listed in subsections (b)(3) through (37) of this Section.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

Section 535.953 Off-Road Communications and Dispatch Center

a) The EEMSV program shall have a designated dispatch center assigned and available twenty-four (24) hours per day every day of the year to receive and dispatch all requests for off-road EEMSV services.
b) The communications and dispatch center shall have the ability to communicate with the off-road EEMSV for non-medical purposes on a separate designated frequency.

(Source: Added at 13 Ill. Reg. 15716, effective September 15, 1989)

SUBPART N: ADMINISTRATIVE WARNINGS AND FINES

Section 535.1000 Administrative Warnings and Fines

a) *The Director shall investigate complaints that a facility, pre-hospital care provider or system participant has violated any provision of the Act or any protocol, standard or rule adopted pursuant thereto. Section 15(c) of the Act)*
b) If the Director finds that such a violation has occurred, he or she may issue to the facility, pre-hospital care provider or system

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participant a *Notice of Administrative Warning*. Such notice shall include:

1) A description of the violation;
2) A citation to the Section of the Act, rule, protocol or standard alleged to have been violated;
3) A description of any corrective action which the facility, pre-hospital care provider or System participant may take in order to abate the Notice of Administrative Warning, if any; and
4) *The opportunity to request an administrative hearing prior to* implementation of the administrative warning, provided such request for a hearing is made within 15 days after mailing or service of the notice. (Section 25 (c), (d) of the Act)

c) In addition, the Director may issue a *Notice of Fine*, under the following conditions:

1) *If the Director determines that the violation creates or created a condition or occurrence presenting a substantial probability that death or serious physical harm to an individual will result therefrom, the Director may impose a fine not exceeding $10,000.*
2) *If the Director determines that the violation creates or created a condition or occurrence which threatens the health, safety or welfare of an individual,* the Director may *impose* a fine not *exceeding $5,000.* (Section 25(c) of the Act)
3) In determining the amount of a fine, the Director shall also consider the following factors:
   A) The severity of the actual or potential harm to an individual.
   B) The numbers and types of protocols, standards, rules or Sections of the Act which were violated in the course of creating the condition or occurrence at issue.
   C) The reasonable diligence exercised by the facility, pre-hospital care provider or System participant to avoid the violation(s) or to reduce the potential harm to individuals.
   D) Efforts by the facility, pre-hospital care provider or System participant to correct the violation(s).
   E) Any previous violation(s) of a like or similar nature by the facility, pre-hospital care provider or System participant.
   F) Any financial benefit to the facility, pre-hospital care provider or System participant of continuing the violation(s).
4) The Notice of Fine shall include:
   A) A description of the violation(s) for which the fine is being imposed.
   B) A citation to the Sections of the Act, rules, protocols or standards alleged to have been violated.
   C) The amount of the fine.
   D) *The opportunity to request an administrative hearing* prior to imposition of the fine, provided such request for a hearing is made within 15 days after *mailing or service of the notice.* (Section 25(c), (d) of the Act)
   E) All fines shall be paid to the Department within the following time periods:
      A) If the fine is not contested, no later than 10 days after the Notice of Fine.
      B) If the fine is contested under Section 25(d) of the Act, no later than 10 days after receipt of the Director's Final Order, unless the facility, pre-hospital care provider or System participant appeals the Director's Final Order pursuant to the provisions of the Administrative Review Law and the reviewing court issues an order staying the Director's Final Order.

d) For purposes of this Section,

1) *"Facility" means* a trauma center, *resource hospital, associate hospital, participating hospital* or another hospital.
2) *"Pre-Hospital Care Provider"* means an ambulance service provider or specialized emergency medical service vehicle that is not *owned, operated, licensed or regulated by any unit of local government,* or an Emergency Medical Technician-Basic (EMT-B) who is not affiliated with an EMS System.
3) *"System Participant"* means an EMS System Coordinator, Associate Hospital EMS Medical Director, Associate Hospital EMS Coordinator, or Field RN, MICN or physician serving on an ambulance or giving voice orders to field personnel. (Section 25(c) of the Act)

(Source: Amended at 19 Ill. Reg. 13299, effective September 15, 1995)

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1) Heading of the Part: Illinois Trauma Center Code

2) Code Citation: 77 Ill. Adm. Code 540

3)

Section Numbers:	Proposed Action:
540.10	Repealer
540.20	Repealer
540.30	Repealer
540.35	Repealer
540.40	Repealer
540.50	Repealer
540.60	Repealer
540.65	Repealer
540.70	Repealer
540.80	Repealer
540.90	Repealer
540.100	Repealer
540.110	Repealer
540.120	Repealer
540.130	Repealer
540.140	Repealer
540.150	Repealer
540.160	Repealer
540.170	Repealer
540.180	Repealer
540.190	Repealer
540.200	Repealer
540.210	Repealer
540.220	Repealer
540.Appendix A	Repealer
540.Illustration A	Repealer

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act, as amended by P.A. 89-177, effective July 19, 1995 [210 ILCS 50]

5) A Complete Description of the Subjects and Issues Involved: These rules implement Section 27 of the Emergency Medical Services (EMS) Systems Act, which requires the Department to designate as Level I or Level II Trauma Centers every hospital that meets the applicable standards. Public Act 89-177 (effective July 19, 1995) repealed substantial portions of the Act and established new provisions in place of those repealed. New rules are needed to implement the revised Act. The Department plans to adopt replacement rules in conjunction with this Repealer. The rule will be included in 77 Ill. Adm. Code 515 (Emergency Medical Services Code).

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect? No

7) Does this Rulemaking Contain an Automatic Repeal Date? No

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8) Does this Rulemaking Contain Any Incorporations By Reference? No

9) Are there any other Proposed Amendments Pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State Mandate.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking: Interested persons may present their comments concerning these rules by writing within 45 days after this issue of the *Illinois Register* to:

Ms. Gail M. DeVito
Division of Governmental Affairs
Illinois Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
(217)782-6187

These rules may have an impact on small businesses. Any small business commenting on these rules shall indicate their status as such, in writing, in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of Small Businesses, Small Municipalities and Not-for-Profit Corporations Affected: None

B) Reporting, Bookkeeping or Other Procedures Required for Compliance: None

C) Types of Professional Skills Necessary for Compliance: None

13) Regulatory agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Repealer begins on the next page:

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TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY MEDICAL SERVICES AND HIGHWAY SAFETY

PART 540
ILLINOIS TRAUMA CENTER CODE (REPEALED)

Section
540.10 Purpose and Applicability
540.20 Definitions
540.30 Incorporated Materials
540.35 Trauma Center Designation Delegation to Local Health Departments
540.40 Trauma Region Designation
540.50 Trauma Center Designation
540.60 Application Process
540.65 Trauma Patient Evaluation
540.70 Level I Trauma Center Designation Criteria
540.80 Level II Trauma Center Designation Criteria
540.90 Trauma Region Plan
540.100 Uniform Reporting Requirements
540.110 Term of Designation
540.120 Renewal of Designation
540.130 Inspections and Investigations
540.140 Denial of Application for Designation or Request for Renewal
540.150 Voluntary Termination of Designation
540.160 Compensatory Provisions and Shortage Areas
540.170 Misrepresentation
540.180 Failure to Develop Protocols
540.190 Confidentiality and Immunity
540.200 Inspection and Revocation of Designation
540.210 Level I Trauma Center Grants
540.220 Trauma Center Fund
APPENDIX A A Request for Designation RFD) Trauma Center
APPENDIX B Minimum Trauma Field Triage Criteria

AUTHORITY: Implementing and authorized by Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Adopted at 11 Ill. Reg. 22153, effective December 1, 1987; amended at 13 Ill. Reg. 13441, effective September 15, 1989; emergency amendment at 14 Ill. Reg. 13856, effective August 13, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 19941, effective December 19, 1990; amended at 15 Ill. Reg. 1084, effective January 15, 1991; amended at 17 Ill. Reg. 8258, effective May 21, 1993; emergency amendment at 17 Ill. Reg. 12439, effective July 7, 1993, for a maximum of 150 days; emergency expired on December 4, 1993; amended at 18 Ill. Reg. 3620, effective February 10, 1994; amended at 19 Ill. Reg. 13417, effective September 15, 1995; repealed at 20 Ill. Reg. _____, effective _____.

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Section 540.10 Purpose and Applicability

The Trauma Care amendments to the Emergency Medical Services (EMS) Systems Act (Act) and these Rules have been adopted to create an organized statewide system for trauma patient care through the designation of Trauma Regions served by Trauma Centers for which standards are set. This Part is applicable to hospitals and emergency medical service providers which participate in a trauma care system. A comprehensive framework for the provision of Emergency Medical Services in Illinois is established in 77 Ill. Adm. Code 535 and 540. Trauma Regions and Trauma Region plans are required by 77 Ill. Adm. Code 540 and local Emergency Medical Service System plans are required by 77 Ill. Adm. Code 535. The Act and this Part apply to all areas of the State, except for those Home Rule units that have adopted their own ordinances.

Section 540.20 Definitions

The definitions listed in this Section, the Act and 77 Ill. Adm. Code 535 apply to this Part.

"Act" means the "Emergency Medical Services (EMS) Systems Act" (Ill. Rev. Stat. 1987, ch. 111 1/2, pars. 5501 et seq.).

"*Advanced Life Support Mobile Intensive Care (ALS/MICU (ALS)*" means an *advanced level of pre-hospital and inter-hospital emergency care that includes basic life support functions (including cardiopulmonary resuscitation (CPR) plus cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, administration of antiarrhythmic agents, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures) initiated for the treatment of real or potential acute life threatening conditions under the direction of a physician licensed to practice medicine in all of its branches or a qualified registered professional nurse MICN or Registered Professional Nurse Field RN and where authorized by the project medical director in an Illinois Department of Public Health approved advanced life support system.* (Section 4.01 of the Act.)

"Affiliate Trauma Hospital" means a hospital that provides initial trauma care in accordance with the Trauma Region Plan established by the participants of the system in the particular region.

"Certified Registered Nurse Anesthetist" or "CRNA" is a licensed registered professional nurse who has had additional education beyond the registered professional nurse requirements at a school program accredited by the National Council on Accreditation, and passed the certifying exam given by the National Council on Certification, and who by participating in forty (40) hours of continuing education every two (2) years, has been recertified by the National Council on

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Recertification.

"Department" means the Department of Public Health, State of Illinois. (Section 4.09 of the Act.)

"Director" means the Director of the Department of Public Health, State of Illinois. (Section 4.10 of the Act.)

"Emergency Medical Services (EMS) Systems" means an organization of providers which through a program plan submitted to and approved by the Department entitles a hospital to utilize qualified personnel specified in the Act to provide or coordinate pre-hospital and inter-hospital emergency care at an advanced or intermediate level, to victims of illness or injury within the area specified in the program plan. Advanced or intermediate level systems may include the utilization of BLS level services. One hospital in each program plan must be designated as the resource hospital. All hospitals and ambulance providers participating in an EMS system must specify their level of participation in the program plan. (Section 4.18 of the Act.)

"Hospital" has the meaning ascribed to that term in the Hospital Licensing Act. (Ill. Rev. Stat. 1987, ch. 111 1/2, pars. 142 et seq. (Section 4.34 of the Act.)

"Level I Trauma Center" means a hospital which: within designated capabilities provides optimal care to trauma patients; participates in an approved EMS system; and is duly designated by the Department. Level I Trauma Centers shall provide all essential services in house 24 hours per day. (Section 4.25 of the Act).

"Level II Trauma Center" means a hospital which: within designated capabilities provides optimal care to trauma patients; participates in an approved EMS system; and is duly designated by the Department. Level II Trauma Centers shall have some essential services available in-house 24 hours per day and other essential services readily available 24 hours per day, as determined by the Department. (Section 4.26 of the Act.)

"Medical Determinations Board" means the advisory body to the Department, as described in The Civil Administrative Code of Illinois (Ill. Rev. Stat. 1987, ch. 127, par. 9.16a et seq.).

"Physician" means a person who is licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 (Ill. Rev. Stat. 1987, ch. 111, pars. 4400-1 et seq.).

"Pre-hospital Care" means those emergency medical services rendered to

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emergency patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to hospitals. (Section 4.16 of the Act.)

"Project Medical Director" or "PMD" means the physician appointed by an advanced life support mobile intensive care System who has the responsibility and authority for total management of the System.

"Registered Nurse" or "Registered Professional Nurse" means a person who is licensed as a professional nurse under the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1987, ch. 111, pars. 3501 et seq.).

"Residency Review Committee for Emergency Medicine" means a committee comprised of members appointed by the American Board of Emergency Medicine, the American Medical Association Council on Medical Education, and the American College of Emergency Physicians. This committee is part of the Accreditation Council for Graduate Medical Education, which operates under the auspices of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialties Society.

"Substantial Compliance" means either compliance with the provisions of the Act and this Part or demonstration that a particular deficiency will not result in a reduction in the standards of trauma care established in the Act or this Part for a similar facility in a similar geographic area.

"Trauma" means any severe injury which involves single or multiple organ systems such as injuries which are potentially or immediately life or limb threatening. (Section 4.27 of the Act.)

"Trauma Center" means a hospital which: within designated capabilities provides optimal care to trauma patients; participates in an approved EMS System; and is duly designated by the Department. (Section 4.28 of the Act.)

"Trauma Center Medical Director" means the trauma surgeon appointed by a Department-designated Trauma Center who has the responsibility and authority for the coordination and management of the trauma services at the Trauma Center. He or she must have twenty-four (24) hour independent operating privileges and shall be board certified in surgery with at least one year of experience in trauma care.

"Trauma Nurse Specialist Course" means a standardized program for training Registered Nurses in trauma patient care, developed and sponsored by the Department and conducted by hospitals authorized by the Department. A Registered Nurse who has successfully completed the

course receives a certificate of completion from the Department.

"Trauma Region" means a geographic area designated by the Department in which trauma services are coordinated through designated trauma centers. (Section 4.29 of the Act.)

"Trauma Region Plan" means the document incorporating the protocols, cooperation agreements, disaster preparedness plan and other guidelines and programs relating to the trauma care within a Trauma Region, created pursuant to Section 540.90 of this Part.

(Source: Amended at 13 Ill. Reg. 15441, effective September 15, 1989)

Section 540.30 Incorporated Materials

a) The following materials are incorporated in this Part:
   1) Standards of nationally recognized organizations
      A) Glasgow Coma Scale
         Champion H.R., Sacco W.J., Carnazzo A.J. et al.
         CritCare Med 9(8): 672-676, 1981 (See Section 540.100)
      B) Revised Trauma Score
         American Trauma Society
         P.O. Box 12526
         Baltimore, Maryland 21203 (See Section 540.100)
      C) Abbreviated Injury Score 1990)
         American Association of Automotive Medicine
         Arlington Heights, Illinois 60005 (See Section 540.100)
      D) Injury Severity Score
         Baker S.P., O'Neil B., Hadon W., et al.
         Journal of Trauma 1974; 14: 187-196 (See Section 540.100)
      E) International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM)
         Alphabetic Index to External Causes of Injury (E-Codes)
         Second Printing 1980
         World Health Organization, Geneva, Switzerland and National Center for Health Statistics, published in the United States of America by Edwards Brothers, Inc., Ann Arbor, Michigan.

b) All incorporations by reference of federal regulations and the standards of nationally recognized organizations refer to the regulations and standards on the date specified and do not include any additions or deletions subsequent to the date specified.

c) The following statutes and State regulations are referenced in this Part:
   1) Federal statutes:
      A) Sections 307 and 309 of the Federal Aviation Act of 1958 (P.L. 85-726, 72 U.S.C. 731).
      B) 14 CFR 157 and 77, Subpart D 1989. (See Sections 540.70(h) and 540.80(i).)

   2) State of Illinois statutes:
      A) Hospital Licensing Act [210 ILCS 85]. (See Sections 540.20, 540.190(b).)
      B) Illinois Nursing Act of 1987 [225 ILCS 65]. (See Sections 540.20, 540.70(e)(1)(B), 540.70(e)(4)(B), 540.70(f)(2), 540.80(f)(1)(B), 540.80(f)(3)(B), 540.80(g)(2).)
      C) Medical Practice Act of 1987 [225 ILCS 60]. (See Sections 540.70, 540.70(e)(1)(A), 540.70(e)(4).A), 540.70(f)(1), 540.80(f)(1)(A), 540.80(f)(3)(A), E40.80(g)(1).)
      D) Code of Civil Procedure [735 ILCS 5]. (See Section 540.190(a).)
   3) State of Illinois regulations:
      A) Aviation Safety [92 Ill. Adm. Code 14.790, 14.792, 14.795). (See Sections 540.70(h) and 540.80(i).)
      B) Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100). (See Section 540.140(b).)

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.35 Trauma Center Designation Delegation to Local Health Departments

a) Delegation of Authority to Implement Trauma Center Designation Program.
   The Department shall delegate authority to local health departments which had established trauma systems pursuant to local ordinances passed prior to January 1, 1990. (Section 29.1 of the Act)

b) Monitoring Delegation.
   The Department shall monitor the performance of local health departments with authority delegated under Section 29.1 of the Act based upon the following *performance criteria:* (Section 29.1 of the Act)
   1) The local health department shall enforce the Act and this Part, consistent with the authority delegated under Section 29.1 of the Act.
   2) The local health department shall designate Trauma Centers consistent with the provisions of the Act and this Part.
   3) Upon notification of a Trauma Center's failure to submit Trauma Registry data to the Department in accordance with Section 540.120, the local health department shall take steps to enforce this requirement within 10 working days.
   4) The local health department shall submit to the Department a copy of the approved Trauma Region Plan required under Section 540.90 at least 30 days prior to implementation.
   5) The local health department shall submit a Quarterly Report to the Department specifying all activities conducted under the delegated authority in accordance with the requirements of the Act and this Part.

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6) The local health department shall submit to the Department copies of all complaints within 2 working days of receipt and copies of all final investigation reports within 10 working days of the completion of the investigation.
7) The local health department shall submit to the Department copies of quarterly Trauma Center medical audits required by Section 540.70(c).

c) Revocation of Delegation.
1) The Department shall revoke authority delegated under this Section for substantial non-compliance with the performance criteria specified in subsection (b). Substantial non-compliance, for the purpose of this Section, means the failure to meet requirements other than a variance from the strict and literal performance which results in unimportant commissions or defects given the particular circumstances involved. Section 29.1 of the Act)
2) Notice of the revocation shall be served upon the local health department by certified mail stating the reasons for revocation and offering an opportunity for an administrative hearing to contest the revocation. Section 29.1 of the Act)
3) The request for a hearing must be received by the Department within 10 working days of the local health department's receipt of notification. Section 29.1 of the Act)
4) All administrative hearings shall be conducted in accordance with the Department's administrative hearing rules entitled "Rules of Practice and Procedure for Administrative Hearings" (77 Ill. Adm. Code 100).

d) Voluntary Termination of Delegation. Upon 60 days written notification to the Director of the Department, the Director of any local health department with delegated authority may relinquish that authority. (Section 29.1 of the Act)

(Source: Added at 14 Ill. Reg. 19041, effective December 15, 1990)

Section 540.40 Trauma Region Designation

a) The Department shall establish trauma center regions consisting of geographic areas within which designated trauma centers provide coordinated trauma services. The Department shall consider the following factors when establishing these regions:
1) geographic distance from available trauma care,
2) transportation modalities,
3) population location and density,
4) the number of predicted trauma victims,
5) hospital resources within the area,
6) existing EMS systems,
7) historical patterns of patient referral,
8) transfer and trauma care within the region,

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9) trauma centers recognized by the Department prior to January 1, 1988, and
10) recommendations from local health authorities.
(Section 26 of the Act.)

b) The Department shall redesignate Trauma Regions under the following criteria:
1) When the criteria set forth in Section 540.40(a) indicate the existing region does not provide adequate services, or
2) Level I trauma services are needed to cover the Region, and
3) Redesignation of Regions will cure deficiencies indicated. The Department shall base redesignation of Trauma Center Regions upon the criteria in subsection 540.40(a) above.

(Source: Amended at 13 Ill. Reg. 15441, effective September 15, 1989)

Section 540.50 Trauma Center Designation

The Department shall attempt to designate a Trauma Center in all areas of the State. A Level I Trauma Center is not required to be located in each Trauma Region. Each Level I Trauma Center shall serve as the resource for all Level II Trauma Centers in the Trauma Regions it is designated to serve. (Section 27(d) of the Act). The Department shall designate as a Level I or Level II Trauma center every hospital that satisfies the applicable standards. (Section 27 of the Act).

(Source: Amended at 13 Ill. Reg. 15441, effective September 15, 1989)

Section 540.60 Application Process

Any hospital seeking designation as a Level I or Level II Trauma Center must submit an application on a form provided by the Department.

Section 540.65 Trauma Patient Evaluation

a) Patients classified as trauma cases in the field or in any pre-hospital setting, in accordance with the Trauma Region Plan, shall be evaluated by the trauma center's attending emergency department physician or designee immediately upon arrival at the emergency department.
b) Hospital triage in Level I and Level II Trauma Centers shall be established so that all patients presented to the emergency department as a result of injury shall be evaluated to assess whether or not the patient should be classified as a trauma case, in accordance with the Trauma Region Plan. This evaluation shall be conducted by the attending emergency department physician or his/her designee or a registered nurse or trauma surgeon who is covering the emergency department. The evaluation shall be conducted within 10 minutes of the patient's arrival at the emergency department.

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c) The response period for trauma, general or specialty surgery, as specified in Section 540.80(c), shall begin when a patient is classified as a trauma case, either by field triage protocols as established by that Region's Trauma Plan, or by hospital triage.

(Source: Amended at 17 Ill. Reg. 8258, effective May 21, 1993)

Section 540.70 Level I Trauma Center Designation Criteria

a) The Level I Trauma Center, under the direction of the Level I Trauma Center Medical Director, shall be responsible for the coordination and management of trauma care in the Trauma Region. This responsibility includes obtaining the cooperation of all Level II Trauma Centers, Affiliate Trauma Hospitals, and EMS Systems in the Trauma Region.

b) The Trauma Center Medical Director shall be a trauma surgeon, board certified in surgery, with at least one year of experience in trauma care and with 24-hour independent operating privileges.

c) The Trauma Center shall provide a Trauma Service separate from the general surgery service, which is an identified hospital service functioning under a designated director and staffed by general or trauma surgeons with one year of experience in trauma, and who are available 24 hours a day in-house. This requirement may be fulfilled by residents with a minimum of four years of general surgery residency training with independent operating privileges, with a staff specialist in call to arrive at the hospital to treat the patient within 30 minutes after notification that his or her services are needed at the hospital.

d) The Trauma Center shall have the following surgical services on call to arrive at the hospital to treat the patient within 30 minutes after notification that their services are needed at the hospital:

1) Cardiothoracic: this requirement may be fulfilled by a cardiothoracic surgeon or a trauma general surgeon with experience in cardiothoracic surgery for life-saving procedures, who must have cardiothoracic privileges;
2) Neurosurgical;
3) Obstetrics;
4) Orthopedic;
5) Vascular;
6) Opthalmologic;
7) Oral-Dental;
8) Otorhinolaryngologic;
9) Plastic.Maxillofacial;
10) Urologic; and
11) Pediatric general surgery.

e) The Trauma Center shall provide the following nonsurgical services within the designated times:

1) Emergency Medicine staffed 24 hours a day in the Emergency Department by:

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A) A physician who has competency in trauma as demonstrated by:
i) board certification by the American Board of Emergency Medicine; or
ii) completion of 12 months of internship, followed by at least 7200 hours of hospital-based Emergency Medicine over at least a 60 month period (including 2800 hours within one 24-month period), verified in writing by the hospital(s) at which the internship and subsequent hours were completed, and continuing medical education totalling 50 hours for each post-internship year in which the physician completed any hospital-based Emergency Medicine hours (the physician may attend less than 50 hours in any given year provided the total number averages 50 hours per year of practice); or
iii) completion of a residency in Emergency Medicine in a residency program approved by the Residency Review Committee for Emergency Medicine; and

B) Registered Professional Nurses.

2) Anesthesiology Services:

A) The anesthesiology service or department shall be supervised by anesthesiologists. "Supervise," for the purposes of this subsection, means to manage, control and direct the services performed, including being present in the trauma center and immediately available for consultation while the services are being performed.

B) Anesthesiology services shall be available 24 hours a day in-house.

C) Direct patient care services may be performed by an anesthesiologist or a certified registered nurse anesthetist (CRNA) acting under the direct supervision of an anesthesiologist.

3) Radiology staffed by:

A) A technician with the ability to perform a computerized axial tomography (CAT) scan 24 hours a day in-house; and

B) A radiologist with the ability to read CAT scans and perform angiography available within 30 minutes. This requirement may be met by a Post Graduate Year (PGY) IV radiology resident or a PGY I resident with six months experience in CT and angiography.

4) Intensive Care Medicine Unit having available 24 hours a day in-house:

A) A physician credentialed by the hospital. This requirement may be fulfilled by second and third year residents who have had adult intensive care training and are under the supervision of a staff physician possessing full adult intensive care privileges;

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B) Registered Professional Nurses; and
C) The following equipment:
i) Airway control and ventilation devices;
ii) Oxygen source with concentration controls;
iii) Cardiac emergency cart;
iv) Electrocardiograph-oscilloscope-defibrillator;
v) Cardiac output monitoring;
vi) Electronic pressure monitoring;
vii) Mechanical ventilator-respirators;
viii) Pulmonary function measuring devices;
ix) Temperature control devices;
x) Drugs, intravenous fluids, and supplies in accordance with the Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically 250.1080, 250.2140, and 250.2210;
xi) Intracranial pressure monitoring devices;
xii) Temporary pacemaker; and
xiii) Intra-aortic balloon pump capability.

5) Laboratory 24 hours a day in-house, providing the following:
A) Standard analysis of blood, urine, and other body fluids;
B) Blood typing and cross-matching;
C) Coagulation studies;
D) Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities (see Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically 250.820);
E) Blood gases and pH determinations;
F) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a 24 hour per day basis; and
G) Drug and alcohol screening.

6) Cardiology -- 60 minutes;
7) Internal Medicine -- 60 minutes;
8) Neuroradiology staffed by a radiologist with the ability to read CAT scans and perform angiography -- 30 minutes; this requirement may be met by a PGY II radiology resident or PGY I resident with six months experience in CT and angiography;
9) Pediatrics -- 60 minutes;
10) Postanesthetic recovery room 24 hours a day;
11) Acute hemodialysis capability 24 hours a day or a transfer agreement;
12) Burn center staffed by Registered Nurses trained in burn care 24 hours a day or a transfer agreement;
13) Acute spinal cord injury management 24 hours a day or a transfer agreement; and
14) Reimplantation service within 30 minutes, or a transfer agreement.

f) The Trauma Center shall meet the following professional staff requirements:

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1) The Emergency Department Director shall be a physician board certified by the American Board of Emergency Medicine;
2) The nurses in charge on each shift in the Emergency Department and the Trauma Service shall be Registered Nurses with at least two years of experience in trauma care. The staffing requirement for the Trauma Services shall be exclusive of the charge nurses and shall include Registered Nurse(s) immediately available for care of any trauma patient and who have completed a Trauma Nurse Specialist Course (77 Ill. Adm. Code 542). A back-up policy shall provide for a nurse with experience evidenced by successful completion of an institution orientation to trauma care in addition to a current Trauma Nurse Core Curriculum (TNCC) or 16 hours equivalent in trauma nursing education, approved by the Department, on a four year period. A back-up schedule must be maintained; and
3) An operating room shall be staffed in-house and available 24 hours a day.

g) The Trauma Center shall provide and maintain the following equipment:
1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen, and mechanical ventilator;
2) Suction devices and equipment (pulmonary and gastric);
3) Electrocardiograph-oscilloscope-defibrillator;
4) Apparatus to establish central venous pressure monitoring;
5) All standard intravenous fluids and administration devices;
6) Sterile surgical sets of procedures standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, thoracostomy, and cut down;
7) Drugs and supplies necessary for emergency care;
8) X-ray and CAT scan capability, 24 hour coverage by in-house technicians;
9) Spinal immobilization equipment;
10) Temporary pacemaker; and
11) Specialized pediatric resuscitation cart in the Emergency Area.

h) The Trauma Center must provide helicopter landing capabilities approved by State and Federal authorities. Section 27(a)(13) of the Act). The helicopter landing capabilities shall:
1) Comply with the Aviation Safety Rules of the Illinois Department of Transportation (92 Ill. Adm. Code 14.790, 14.792, 14.795);
2) Be covered by a favorable airspace determination letter issued by the Federal Aeronautics Administration pursuant to Sections 307 and 309 of the Federal Aviation Act of 1958, and 14 CFR Part 157 and 14 CFR Part 77, Subpart D; and
3) Be provided on the campus of the Trauma Center.

Out-of-state trauma centers are exempted from this subsection (h) but must provide proof of compliance with their state's rules that govern aviation safety.

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i) The Trauma Center shall perform focused outcome analyses of its trauma services on a quarterly basis, and shall have the results available for review at the request of the Department.

j) The Trauma Center shall provide a proposed Trauma Region Plan, which shall include the following:

1) The protocols for treating patients in the Level I Trauma Center;

2) The protocols for transferring trauma patients to more specialized care;

3) Procedures for the development, maintenance and updating of region-wide protocols as required in Section 540.90 of this Part;

4) Recommendations for Level II Trauma Center designations and Affiliate Trauma Hospitals to serve the Trauma Region;

5) Sample agreements with the recommended hospitals outlining their respective responsibilities in providing Trauma Services and the integration of communications in the Trauma Region;

6) Sample agreements with all EMS systems providing services within the Trauma Region to assure integration of communications and transportation;

7) A disaster preparedness plan which explains the actions and responsibilities of the Level I Trauma Center, the EMS systems, the recommended Level II Trauma Centers and the recommended Affiliate Trauma Hospitals within the Trauma Region. This may incorporate or consist of existing Disaster Plans; and

8) The procedures for reviewing the focused outcome analyses performed by Level II Trauma Centers within the Trauma Regions to assure compliance with the written agreements required by Section 540.90 of this Part.

k) The Trauma Center shall develop a policy that identifies resource limitations that would result in the diversion of a trauma patient to another facility. This policy shall include notification procedures for pre-hospital personnel and for surrounding trauma centers.

1) Such diversion must be reported to the Department by telephone if it occurs during business hours. Otherwise, written notification of diversion must be sent no more than 48 hours following the diversion.

2) Both forms of notification shall include at minimum:

A) The name of the Trauma Center;

B) Date and time resource limitation started and ended; and

C) Reason for resource limitation.

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.80 Level II Trauma Center Designation Criteria

a) A Level II Trauma Center, under the direction of a Level II Trauma Center Medical Director, shall be responsible for providing trauma care in accordance with the Trauma Region Plan.

b) The Trauma Center Medical Director shall be a trauma surgeon, board

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certified in surgery, with at least one year of experience in trauma care and with 24-hour independent operating privileges.

c) The Trauma Center shall provide a Trauma Service, which is an identified hospital service functioning under a designated director and staffed by general or trauma surgeons with one year of experience in trauma, who arrive at the hospital to assess and treat the trauma patient within 30 minutes of the patient being declared as a trauma pursuant to Section 540.65 of this Part. The trauma surgeon requirement may be fulfilled by residents with a minimum of four years general surgery residency training with independent operating room privileges with a staff specialist on call to arrive at the hospital to treat the patient within 30 minutes after notification that his or her services are needed at the hospital. The Trauma Center shall maintain a call schedule that identifies at least a primary surgeon and a back-up surgeon.

1) The Trauma Center shall have the option of allowing the emergency department personnel to determine that a trauma patient with isolated injuries may be treated by one of the specialty surgical services listed in subsection (d) or (e) below, in lieu of a trauma surgeon. Such services shall be provided within 60 minutes after notification of the surgeon that his or her services are needed at the hospital, except for neurosurgery, which shall be provided within 30 minutes.

2) A Trauma Center electing to implement subsection (c)(1) above shall follow the protocols established in Section 540.90 (c)(1)(A) of this Part.

d) The Trauma Center shall provide the following surgical services within 60 minutes:

1) Cardiothoracic; this requirement may be fulfilled by a cardiothoracic surgeon or a trauma general surgeon with experience in cardiothoracic surgery for life-saving procedures, who must have cardiothoracic privileges;

2) Obstetrics;

3) Orthopedic; and

4) Urologic.

e) The Trauma Center shall have the following surgical specialties on call to arrive at the hospital to treat the patient within 60 minutes after notification that their services are needed. These services may be provided by written transfer agreement. These services must be provided according to subsection (c)(1) for isolated injuries when the trauma surgeon is not required to respond.

1) Neurologic;

2) Ophthalmologic;

3) Oral-Dental;

4) Otorhinolaryngologic;

5) Reimplantation; and

6) Plastic Maxillofacial.

f) The Trauma Center shall provide the following nonsurgical services

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within the designated times:

1) Emergency Medicine staffed 24 hours a day in the Emergency Department by:
   A) A physician who has competency in trauma as demonstrated by:
      i) board certification by the American Board of Emergency Medicine; or
      ii) completion of 12 months of internship, followed by at least 7,000 hours of hospital-based Emergency Medicine over at least a 60-month period (including 2800 hours within the 24-month period), verified in writing by the hospital(s) at which the internship and subsequent hours were completed, and continuing medical education in Emergency Medicine totalling 50 hours for each post-internship year in which the physician completed any hospital-based Emergency Medicine hours. The physician may attend less than 50 hours in any given year provided the total number averages 50 hours per year of practice; or
      iii) completion of a residency in Emergency Medicine in a residency program approved by the Residency Review Committee for Emergency Medicine; and
   B) Registered Professional Nurses.
2) Anesthesiology Services:
   A) Anesthesiology services shall be in compliance with the Hospital Licensing Act and the Hospital Licensing Requirements, 77 Ill. Adm. Code 250.1410. Staff shall be on call to arrive at the hospital to administer anesthesia within 30 minutes after notification that their services are needed at the hospital.
   B) Direct patient care services may be performed by an anesthesiologist or a certified registered nurse anesthetist (CRNA).
3) Laboratory -- 24 hours a day in-house, providing the following:
   A) Standard analysis of blood, urine, and other body fluids;
   B) Blood typing and cross-matching;
   C) Coagulation studies;
   D) Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities. See Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically Section 250.820;
   E) Blood gases and pH determinations;
   F) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a 24 hour per day basis; and
   G) Drug and alcohol screening.
4) Radiology staffed by:
   A) A technician with the ability to perform a CAT scan available within 30 minutes; and

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   B) A radiologist with the ability to read CAT scans and perform angiography available within 60 minutes. This requirement may be met by a PGY II radiology resident or PGY I resident with six months experience in CT and angiography.
5) Cardiology -- 60 minutes.
6) Internal Medicine -- 60 minutes.
7) Postanesthetic recovery room staffed and available within 30 minutes.
8) Intensive Care Medicine Unit having available the following:
   A) A physician credentialed by the hospital and available within 30 minutes. This requirement may be fulfilled by second and third year residents who have had adult intensive care training and are under the supervision of a staff physician possessing full adult intensive care privileges;
   B) Registered Professional Nurses 24 hours a day in the Intensive Care Unit; and
   C) The following equipment 24 hours a day in-house:
      i) Airway control and ventilation devices;
      ii) Oxygen source with concentration controls;
      iii) Cardiac emergency care;
      iv) Electrocardiogram-oscilloscope-defibrillator;
      v) Temperature control devices;
      vi) Drugs, intravenous fluids, and supplies in accordance with the Hospital Licensing Requirements, 77 Ill. Adm. Code 250, specifically Sections 250.1050, 250.2140, and 250.2710;
      vii) Temporary pacemaker; and
      viii) Mechanical ventilator-respirators.
9) Pediatrics -- 60 minutes.
10) Acute hemodialysis capability 24 hours a day or a transfer agreement.
11) Burn center staffed by Registered Nurses trained in burn care 24 hours a day or a transfer agreement.
12) Acute spinal cord injury management 24 hours a day or a transfer agreement.

g) The Trauma Center shall meet the following professional staff requirements:
   1) The Emergency Department Director shall be a physician board certified by the American Board of Emergency Medicine, or a physician who has completed 12 months of internship, followed by 60 months plus 7,000 hours of hospital based Emergency Medicine (2800 of the 7,000 hours must be completed within the 24-month period), and 50 hours of continuing medical education in Emergency Medicine for each complete year of practice, or a physician who has completed a residency program approved by the Residency Review Committee for Emergency Medicine;
   2) The nurse in charge on each shift in the Emergency Department and for the Trauma Service shall be a Registered Nurse with at least

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two years experience in trauma care. The staffing requirement for the Trauma Services shall be exclusive of the charge nurse and shall include Registered Nurse(s) immediately available for care of any trauma patient and who have completed a Trauma Nurse Specialist Course (77 Ill. Adm. Code 542). A back-up policy shall provide for a nurse with experience evidenced by Trauma Nurse Core Curriculum (TNCC) or 16 hours equivalent in trauma nursing education, approved by the Department, in a four year period. A back-up schedule must be maintained; and

3) An operating room shall be staffed and available within 30 minutes 24 hours a day.

h) The Trauma Center shall provide and maintain the following equipment:

1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen, and mechanical ventilator;
2) Suction device;
3) Electrocardiograph-oscilloscope-defibrillator;
4) Apparatus to establish central venous pressure monitoring;
5) All standard intravenous fluids and administration devices;
6) Sterile surgical sets of procedures standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, thoracostomy, and cut down;
7) Gastric lavage equipment;
8) Drugs and supplies necessary for emergency care;
9) Xray and CAT scan capability, available within 30 minutes;
10) Spinal immobilization equipment;
11) Temporary pacemaker; and
12) Specialized pediatric resuscitation cart in the Emergency Area.

i) *The Trauma Center must provide helicopter landing capabilities approved by State and Federal authorities.* (Section 27(a)(13) of the Act) The helicopter landing capabilities shall:

1) Comply with the Aviation Safety Rules of the Illinois Department of Transportation (92 Ill. Adm. Code 14.710, 14.792, 14.795);
2) Be covered by a favorable airspace determination letter issued by the Federal Aeronautics Administration pursuant to Sections 107 and 139 of the Federal Aviation Act of 1958, and 14 CFR Part 157 and 14 CFR Part 77, Subpart D; and
3) Be provided on the campus of the Trauma Center.

Out-of-state trauma centers are exempted from this subsection (i) but must comply with their state's rules that govern aviation safety.

j) The Trauma Center shall perform focused outcome analyses of its trauma services on a quarterly basis. The results of which shall be forwarded to the Level I Trauma Center serving the Trauma Region; and shall have the results available for review at the request of the Department.

k) The Trauma Center shall provide annually written protocols concerning the following:

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1) The treatment of trauma patients in the Trauma Center; and
2) The transfer of trauma patients to the Level I Trauma Center serving the Trauma Region or a more specialized level of care.

l) The Trauma Center shall develop a policy that identifies resource limitations that would result in the diversion of a trauma patient to another facility. This policy shall include notification procedures for pre-hospital personnel and for surrounding trauma centers.

1) Such diversion must be reported to the Department by telephone if it occurs during business hours. Otherwise, written notification of diversion must be sent no more than 48 hours following the diversion.
2) Both forms of notification shall include at minimum:
A) The name of the Trauma Center;
B) Date and time resource limitation started and ended; and
C) Reason for resource limitation.

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.90 Trauma Region Plan

a) Within six months of designation by the Department, the Level I Trauma Center serving a Trauma Region shall submit to the Department a Trauma Region Plan. If more than one Level I Trauma Center serves a Trauma Center Region, then the Level I Trauma Centers must establish and implement an agreement of cooperation for the review and coordination of services within the Trauma Center Region.

b) *The Level I Trauma Center shall assemble a committee which shall develop the Trauma Region Plan. The Committee shall consist of:*

1) *The Trauma Region's Level I Trauma Center Medical Director;*
2) *The Trauma Region's Level II Trauma Center Medical Directors;*
3) *The Project Medical Directors from all the EMS Systems within the Trauma Region;*
4) *The Project Medical Directors from all EMS Systems outside the Trauma Region which transfer patients into the Trauma Region;*
5) *Administrators of the associate hospitals of the EMS System of which the prehospital care provider is a part;*
6) *Nursing Directors of the associate hospitals of the EMS System of which the prehospital care provider is a part;*
7) *A representative of an ambulance service provider from each EMS system within the trauma region.* Section 27e of the Act)

c) The Trauma Region Plan shall include but not be limited to the following:

1) Protocols addressing the following:
A) The treatment of trauma patients in each Trauma Center in the Trauma Region. These protocols shall address which trauma patients with isolated injuries may be treated by a specialty surgical service in lieu of a trauma surgeon, pursuant to Section 540.80 (c)(1) of this Part. The

protocols shall also specify that any patient not specifically identified as one who may be treated by a specialty surgical service shall be treated by a trauma surgeon;

B) The evaluation and identification of when patients shall be transported to a Trauma Center, Affiliate Trauma Hospital, or other hospital;

C) The bypassing of any Level Trauma Hospital;

D) The transfer of trauma patients to a Level I Trauma Center or to more specialized care;

E) Field triage (See Section 540.Appendix B);

F) Hospital triage (See Section 540.Appendix B);

G) Medical legal issues; and

H) Local conflict mediation.

2) Written agreements addressing the following:

A) The respective responsibilities of the Level I Trauma Center, the Level II Trauma Centers, the Affiliate Trauma Hospitals and the EMS Systems within the Trauma Region in providing integrated trauma services, transportation and communications; and

B) The respective responsibilities of EMS Systems and hospitals providing specialty care outside of the Trauma Region in providing trauma patient care.

3) A Disaster Preparedness Plan which includes the actions and responsibilities of the Level I Trauma Center, the Level II Trauma Centers, the Affiliate Trauma Hospitals and the EMS Systems within the Trauma Region.

4) A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients at all Trauma Centers and Affiliate Trauma Hospitals.

5) A program for informing all participants involved in the care of trauma patients within the Trauma Region of field triage treatment protocols and all other aspects of the Trauma Region Plan.

6) Written Protocols

A) Written Protocols which *shall provide* that a *person shall not be transported to a facility other than the regional trauma center or the nearest trauma center or hospital unless* the Project Medical Director or his qualified designee has determined and certified that, based upon the reasonable risks and benefits to the patient, and based on the information available at the time:

i) *the medical benefits reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility, and*

ii) *the more distant facility has available space and qualified personnel for the treatment of the patient.* (Section 27e of the Act) A trauma center, associate hospital or participating hospital affiliated with the EMS System may be presumed to have available space and qualified personnel in accordance with its level of participation within the System, unless such facility has notified the Project Medical Director that it has a shortage or limitation of space or qualified personnel.

B) The Trauma Region's protocols shall be consistent with the protocols of the EMS System within the Region, including but not limited to, a System's protocols for accommodating the patient's choice of facility other than the nearest hospital or trauma center.

C) For purposes of this subsection, the "nearest hospital" is the hospital which is closest to the scene of the emergency as determined by travel time, and which operates a full-time emergency department at the minimum level recognized by the System in its Department approved Program Plan. The "nearest trauma center" is either the Level I Trauma Center serving the trauma region in which the EMS System is located or the Level II Trauma Center which is closest to the scene of the emergency as determined by travel time.

d) Revised Trauma Score

1) The Revised Trauma Score, as specified by the American College of Surgeons, shall be used in all Trauma Regions. The Revised Trauma Score is determined by using the following criteria:

A) Respiratory Rate	Value	Points
	10-29/Min	4
	greater than 29/Min	3
	6-9/Min	2
	1-5/Min	1
	0	0
B) Systolic Blood Pressure	greater than 89	4
	76-89	3
	50-75	2
	1-49	1
	no pulse	0

C) Glasgow Coma Scale

i) Eye Opening Response	Points
Spontaneous	4
To Voice	3
To Pain	2
None	1

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ii) Best Verbal Response

Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Sounds	2
None	1

iii) Best Motor Response

Obeys Commands	6
Localizes (Pain)	5
Withdraw (Pain)	4
Flexion (Pain)	3
Extension (Pain)	2
None	1

Total GCS	Revised Trauma Points
13-15	* 4
9-12	* 3
6-8	* 2
4-5	* 1
3	* 0

REVISED TRAUMA SCORE = Total Points A + B + C

2) Each Trauma Region may include other criteria in addition to the Revised Trauma Score in defining a trauma patient and specifying where trauma patients should be transported according to the severity of the injury.

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.100 Uniform Reporting Requirements

a) Each facility shall have available to the Trauma Service use of a Microsoft Disc Operating System (MS-DOS) IBM Compatible microcomputer that meets the following minimum standards: 386 microprocessor, two megabytes Random Access Memory (RAM), 40 megabytes hard drive, color monitor and back-up capability. The microcomputer must be available for the Illinois Trauma Registry to operate properly. Additional equipment required is a modem and printer. The Department shall provide Trauma Registry software for use by the facility. This software shall be used for data collection and shall have a provision to prepare electronic media reports to the Department on a quarterly basis.

b) The facility shall provide the following information on each reportable trauma patient:
   1) Patient name;
   2) Date of birth;

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   3) Sex;
   4) Race;
   5) Home zip code;
   6) Location of geographical site where injury occurred;
   7) Type of site where injury occurred (i.e., home, school, road, etc.);
   8) Mechanism of injury (International Classification of Disease (ICD)9 E codes - 4 digits);
   9) Initial Trauma Triage score (such as the Glasgow Coma Scale or the Trauma Score);
   10) Pre-hospital treatment;
   11) Trauma triage score upon arrival to hospital;
   12) Treatment prior to surgery;
   13) Times of:
      A) injury,
      B) start of pre-hospital treatment,
      C) arrival in Emergency Department, and
      D) start of surgery;
   14) Trauma score prior to transfer;
   15) Method and reason for transfer;
   16) Trauma score upon arrival at the next level of care;
   17) Treatment prior to surgery transfer;
   18) Surgical procedures;
   19) Complications;
   20) Abbreviated Injury Score for each injury (Abbreviated Injury Score of the American Association of Automotive Medicine);
   21) Injury Severity Score (range from 1 to 75) (I.S.S.);
   22) Total hospital stay (subdivided into Intensive Care Unit (ICU) and non-ICU);
   23) Patient outcome (died, discharged, transferred, etc.);
   24) ICD9 N Code for nature of illness;
   25) Method of payment used by patient;
   26) Total charges for care privided;
   27) Date of initial injury; and
   28) Date injury was identified or diagnosed by health care provider.

c) Reportable trauma patients
   1) A reportable trauma patient is one who was involved in a traumatic event and:
      A) was transferred to the trauma center from another trauma center, or
      B) was transferred from the trauma center to another trauma center, or
      C) was admitted to the trauma center as an inpatient, or
      D) was assigned an observation status with disposition outside of the Emergency Department, or
      E) was dead on arrival (DOA), or
      F) died in the emergency department (DIE), or
      G) signed out against medical advice (AMA).

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2) A traumatic event is one in which there was a transfer of energy resulting in injury, involving any of the following:
   A) aircraft;
   B) watercraft;
   C) motor vehicles;
   D) railway;
   E) recreational vehicles;
   F) farm machinery;
   G) animals, including bites;
   H) explosion;
   I) falls;
   J) thermal chemical radiation injuries;
   K) lightning;
   L) weather related (tornado, flood, blizzard) injuries;
   M) struck by falling object;
   N) sports related;
   O) caught between objects;
   P) cutting or piercing instruments or objects;
   Q) firearms;
   R) electric current;
   S) suicide or self-inflicted injury;
   T) homicide;
   U) injury inflicted by others;
   V) hanging;
   W) strangulation;
   X) inhalation.

d) Illinois trauma registry reporting schedule

Patients Discharged	Report Date
January - March	June 30
April - June	September 30
July - September	December 31
October - December	March 31

e) Data shall be collected for all trauma patients in the State for each level of Injury Severity Score mean mortality rates, and standard deviations shall be calculated using standard statistical methods. Trauma Centers with mortality rates more than one standard deviation above the mean in three or more ISS levels shall have an in-depth evaluation by the Department prior to renewal of designation. Trauma Centers with mortality rates more than two standard deviations above the mean in any ISS level less than 25 shall also be evaluated for compliance with the Act and this Part prior to renewal of designation. The Trauma Center's mortality rate shall not constitute the sole basis for refusing to renew a trauma center's designation.

f) Data collected from individual Trauma Centers shall be cross-referenced with Vital Records Death Certificates to confirm accuracy.

g) Annual reports shall be prepared by the Department presenting summary data to allow Trauma Centers and the public to evaluate performance. This data shall have all hospital and patient identifiers removed.

h) All data received by the Department shall be kept confidential. Patient identifiers shall be kept in such a way to assure that confidentiality is maintained and is not available to the public.
   1) *All reports and records made pursuant to the Act and maintained by the Department and other appropriate persons, officials and institutions pursuant to the Act shall be confidential. Information shall not be made available to any individual or institution except to:*
      A) *Appropriate staff of the Department;*
      B) *Any person engaged in a bona fide research project, with the permission of the Director of Public Health, except that no information identifying the subjects of the reports or the reporters shall be made available to researchers unless the Department requests and receives consent for such release pursuant to the provisions of this Section; and*
      C) *The Council, except that no information identifying the subjects of the reports or the reporters shall be made available to the Council unless consent for release is requested and received pursuant to the provisions of this Section. Only information pertaining to Head and Spinal Cord Injuries as defined in Section 1 of the Head and Spinal Cord Injury Act [410 ILCS 515] shall be released to the Council.*
      (Section 3 of the Head and Spinal Cord Injury Act)
   2) *The Department shall not reveal the identity of a patient, physician or hospital, except that the identity of the patient may be released upon written consent of the patient, parent or guardian, the identity of the physician may be released upon written consent of the physician, and the identity of the hospital may be released upon written consent of the hospital.* (Section 3 of the Head and Spinal Cord Injury Act)
   3) *The Department shall request consent for release from a patient, a physician or hospital when issuing by the applicant for such release that obtaining the identities of certain patients, physicians or hospitals is necessary for his bona fide research directly related to the objectives of the Act.* (Section 3 of the Head and Spinal Cord Injury Act)

i) Availability of Registry Information
   1) All requests by medical or epidemiologic researchers for confidential registry data must be submitted in writing to the registry. The request must include a study protocol which contains: objectives of the research; rationale for the research, including scientific literature justifying current proposal; overall study methods, including copies of forms, questionnaires, and consent forms used to contact facilities,

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physicians or study subjects, including methods for documenting compliance with 42 CFR 2A, pars. 4 a-j, 6 a-b, 7 a-b1; methods for the processing of data; storage and security measures taken to insure confidentiality of patient identifying information; time frame of the study; a description of the funding source of the study (e.g., Federal Contract); the curriculum vitae of the principal investigator; and a list of collaborators. In addition, the research request must specify what patient or facility identifying information is needed and how the information will be used.

2) All requests to conduct research and modifications to approved research proposals involving the use of data which includes patient or facility identifying information shall be subject to a review to determine compliance with the following conditions:
   A) A request for patient or facility identifying information contains stated goals or objectives.
   B) The request documents the feasibility of the study design in achieving the stated goals and objectives.
   C) The request documents the need for the requested data to achieve the stated goals and objectives.
   D) The requested data can be provided within the timeframe set forth in the request.
   E) The request documents that the researcher has qualifications relevant to the type of research being conducted.
   F) The research will not duplicate other research already underway using the same registry data when both require the contact of a patient, reporting facility or physician about an individual patient involved in the previously approved concurrent research.
   G) Other such conditions relevant to the need for the patient or facility identifying information and the patient's confidentiality rights because the Department will only release the patient, physician in accordance with the provisions of this Section, or facility identifying information which is necessary for the research.
3) Research Agreements
   A) The Department will enter into research contracts for all approved research requests. These contracts shall specify exactly what information is being released and how it can be used in accordance with the standards in subsection c) above. In addition, the researcher shall include an assurance that:
      i) Use of data is restricted to the specifications of the protocol;
      ii) Any and all data which may lead to the identity of any patient, research subject, physician, other person, or hospital is strictly privileged and confidential and agrees to keep all such data strictly confidential at

all times;
      iii) All officers, agents and employees will keep all such data strictly confidential, will communicate the requirements of this subsection (i)(3) to all officers, agents, and employees, will discipline all persons who may violate the requirements of this subsection (i)(3), and will notify the Department in writing within 48 hours after any violation of this subsection (i)(3), including full details of the violation and corrective actions to be taken;
      iv) All data provided by the Department pursuant to the contract may only be used for the purposes named in the contract and that any other or additional use of the data may result in immediate termination of the contract by the Department;
      v) All data provided by the Department pursuant to the contract is the sole property of the Department and may not be copied or reproduced in any form or manner and agrees to return all data and all copies and reproduction of the data to the Department upon termination of the contract.
   B) Any departures from the approved protocol must be submitted in writing and approved by the Director in accordance with subsection c) 2) above prior to initiation. No patient or facility identifying information may be released by a researcher to a third party.
   4) The Department shall disclose individual patient or facility information to the reporting facility, which originally supplied that information to the Department, upon written request of the facility.
j) The patient identifying information submitted to the Department by those entities required to submit information under the Act and this Part is to be used in the course of medical study under Part 21 of Article 8 of the Code of Civil Procedure (735 ILCS 5). Therefore, this information is privileged from disclosure by Part 21 of Article 8 of the Code of Civil Procedure.
k) The identity of any facility, or any group of facts which tends to lead to the identity, of any person whose condition or treatment is submitted to the Department shall not be open to public inspection or dissemination. Such information shall not be available for disclosure, inspection or copying under the Freedom of Information Act or the State Records Act. All information for specific research purposes may be released in accordance with procedures established by the Department in this Section.
l) Every hospital shall provide representatives of the Department with access to information from all medical, pathological, and other pertinent records and logs related to reportable registry information. The mode of access and the time during which this access will be

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provided shall be by mutual agreement between the hospital and the Department. The Department shall not require hospitals to provide information on cases which are dated more than two years before the Department's request for further information.

m) Every hospital shall provide access to information regarding specified patients or other patients specified for research studies, related to reportable registry information, conducted by the Department. Any disputes as to access shall be resolved by the hospital and the Department within 30 days after requests for access have been denied.

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.110 Term of Designation

A Trauma Center designation shall expire one year after the date of award unless the designee has made a timely and sufficient request for renewal of the designation. (See 12(4) of the Act.)

Section 540.120 Renewal of Designation

All requests for renewal of Trauma Center designations shall be filed in writing with the Department before the designation expiration date. If the renewal request meets the requirements of this Section, the existing designation shall continue in full force and effect until a final Department decision on the renewal request has been issued.

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.130 Inspections and Investigations

The Department shall conduct a site visit to inspect the facilities of all applicants, both initial and renewal, for compliance with this Part. A report of the inspection shall be provided to the Director within 30 days after the site visit. Within 30 days of receipt of the inspection report, the Director may accept or reject the plan for designation based upon the findings and recommendations of such report and other relevant information including any comments provided by the State Emergency Medical Services Council and local health authorities. (Section 23(c) of the Act)

(Source: Amended at 19 Ill. Reg. 13417, effective September 15, 1995)

Section 540.140 Denial of Application for Designation or Request for Renewal

a) The Department shall deny an application for designation or a request for renewal of a designation when its findings show one or more of the following:
   1) Failure to substantially comply with the Act or this Part;
   2) A determination that the Trauma Center's annual morbidity and mortality rates exceed the State average for such rates;

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b) The Department shall provide written notice, via certified mail, of its decision to deny an application for designation or a request for renewal of a designation. The applicant shall have ten (10) days after receipt of the written notice to make a written request for an administrative hearing to contest the Department's decision. All administrative hearings shall be conducted in accordance with the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100).

Section 540.150 Voluntary Termination of Designation

Any Level Trauma Center may voluntarily terminate its designation prior to its expiration date by notifying the Department in writing. Such notification shall include the anticipated date of termination, which shall not exceed sixty (60) days after notice is received by the Department, and shall describe the procedures taken by the Trauma Center to notify the providers, hospitals, EMS systems and other Trauma Centers in the Trauma Region.

Section 540.160 Compensatory Provisions and Shortage Areas

The Department may establish alternative standards for the designation of Level I Trauma Centers in certain medical shortage areas of the State as designated by the Department in which all requirements for optimum Trauma Care cannot be immediately achieved or implemented due to significant resource limitations. (Section 27 (c) of the Act).

a) Medical shortage area designation and specific compensatory provisions may be requested by submitting a written proposal to the Department. Any written proposal shall include a detailed description of the procedure(s) to be used in lieu of the requirements of the rules of this Part, a detailed description of the reasons the facility qualifies as a medical shortage area, and a detail description of the compensatory provisions that are necessary and how specifically requested compensatory provisions will provide a standard of care equivalent to that provided by the rules of this Part.
   1) The Department shall utilize the following criteria to determine whether a particular area of the State is a medical shortage area:
      A) number of physicians and their subspecialties in the area;
      B) number of traumatic deaths in hospitals in the area;
      C) number of trauma patients in the area;
      D) number of patients transferred from the area;
      E) number of trauma injuries in the pre-hospital care setting; and
      F) more than seventy-five (75) miles from a designated Level I Trauma Center.
   2) The capability of the alternative procedure(s) to provide an orderly, efficient, and safe provision of trauma services which

ensure quality of care equivalent to that provided by the rules of this Part shall be the basis for approval or denial of the request for approval of a compensatory provision.

b) The Department shall notify the applicant in writing of its decision to either grant or deny the request for designation as a medical shortage area and approval of specific compensatory provisions within 60 days of receipt of the request.

(Source: Amended at 13 Ill. Reg. 15441, effective September 15, 1989)

Section 540.170 Misrepresentation

After July 1, 1988, no person shall use the phrase "Trauma Center" or words of similar meaning in relation to himself or hold himself out as a Trauma Center without first obtaining designation therefor pursuant to this Act. (Section 28 of the Act.)

Section 540.180 Failure to Develop Protocols

If a Trauma Region Plan Committee (Section 540.90(b) of this Part) fails to develop the protocols required by Section 540.90(c)(1)(A) through (D) of this Part within six (6) months after the designation of a Level I Trauma Center, the Department may prescribe such protocols for use by the EMS Systems within or serving that Trauma Region. In developing such protocols, the Department shall seek the advice of the Medical Determinations Board and Level I Trauma Center Medical Directors from other Trauma Regions.

Section 540.190 Confidentiality and Immunity

a) *All information contained in or relating to any medical audit performed by a trauma center of its trauma services or the trauma services of another hospital pursuant to Section 27 of the Act shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure, as amended.* (Section 27.1(a) of the Act).

b) *Hospitals and individuals that perform or participate in medical audits of trauma centers pursuant to Section 27 of the Act shall be immune from civil liability to the same extent as provided in Section 10.2 of the Hospital Licensing Act, as amended.* (Section 27.1(b) of the Act).

(Source: Added at 13 Ill. Reg. 15441, effective September 15, 1989)

Section 540.200 Inspection and Revocation of Designation

a) *The Department shall have the authority to inspect designated trauma centers in order to assure substantial compliance with the provisions of the Act and this Part.* Substantial compliance, for the purpose of this Section, means compliance with the requirements of this Part, except for a variance from the strict and literal performance which results in unimportant omissions or defects given the particular circumstances involved. *Information received by the Department through filed reports, inspection or as otherwise authorized under the Act shall not be disclosed publicly in such a manner as to identify individuals or hospitals, except in a proceeding involving the denial or revocation of a trauma center designation.* (Section 27 of the Act)

b) *If the Director determines that a trauma center is in violation of the Act, or any rule of this Part, the Director shall take the following action, as appropriate:*

1) *If the Director determines that the violation presents a substantial probability that death or serious physical harm will result and if the trauma center fails to eliminate the violation immediately or within a fixed period of time, not exceeding 15 days, as determined by the Director, the Director may immediately revoke the trauma center designation. The trauma center may appeal the revocation by requesting a hearing as provided by Section 25 of the Act.*

2) *If the Director determines that the violation does not present a substantial probability that death or serious physical harm will result, the Director shall request a plan of correction which shall be subject to the Department's approval. The trauma center shall have 10 days after the receipt of the notice of violation in which to submit a plan of correction. The Department may extend this period for up to 30 days.* The Department will consider the following factors in determining whether or not to extend the period for submission of the plan of correction, to a maximum of 30 days: whether a substantial probability that death or serious physical harm will result still exists, and whether the delay could lead to physical harm. *The plan shall include a fixed time period not in excess of 90 days within which violations are to be corrected. The plan of correction and the status of its implementation by the trauma center shall be provided, as appropriate, to all participants of the appropriate EMS systems. If the Department rejects a plan of correction, it shall send notice of the rejection and the reason for the rejection to the trauma center. The trauma center shall have 10 days after receipt of the notice of rejection in which to submit a modified plan. If the modified plan is not timely submitted, or if the modified plan is rejected, the trauma center shall follow an approved plan of correction imposed by the Department. If, after notice and opportunity for hearing, the Director determines that a trauma center has failed to comply with an approved plan of correction, the Director may revoke the trauma center designation. Such notice and hearing shall conform to the provisions of Section 25 of the Act.* (Section 27 of the Act).

3) The degree of danger or harm to a patient or patients which is

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posed by a violation of this Part shall be assessed using the following factors:

A) Whether the patient or patients of the facility are able to recognize conditions or occurrences which may be harmful and are able to take measures for self-preservation and self-protection. The extent of nursing care required by the residents as indicated by review of patient needs will be considered in relation to this determination.

B) Whether the patient or patients have access to the area of the facility in which the condition or occurance exists and the extent of such access. A facility's use of carriers, warning notices, instructions to staff and other means of restricting patient access to hazardous areas will be considered.

C) Whether the condition or occurrence was the result of inherently hazardous activities or negligence by the facility.

D) Whether the patient or patients of the facility were notified of the condition or occurrence and the promptness of such notice. Failure of the facility to notify patients of potentially harmful conditions or occurrences will be considered. The adequacy of the method of such notification and the extent to which such notification reduced the potential danger to the residents will also be considered.

(Source: Added at 15 Ill. Reg. 1084, effective January 15, 1991)

Section 540.210 Level I Trauma Center Grants

The Department of Public Health may make grants to hospitals meeting the criteria for and designated as Level I Trauma Centers based on need. (Section 27.2 of the Act). Because of their unique contributions to patient care, the trauma centers of Illinois are a very valuable resource to the citizens of the State of Illinois. Due to the special responsibilities of Level I Trauma Centers within regional trauma systems, Level I Trauma Centers experience additional financial costs. The Department of Public Health acknowledges that these additional costs exist and will make grants to Level I Trauma Centers based upon need as reflected in the grant funding methodology set forth in this Section. The purpose of the grants described in this Part is to assist Level I Trauma Centers in carrying out their responsibilities within regional trauma systems.

a) In order to participate in Level I Trauma Center grants, a Level I Trauma Center must submit a notice of intent to participate for funding under subsection (b)(2)(A), and an application for funding under subsection (b)(2)(B), on forms provided by the Department by a date set by the Department. The application shall include the following:

1) The name, address and person responsible for carrying out the provisions of a grant under this program.

2) A brief description of the reasons the grant is being requested including a specific explanation of the hospital's financial situation as it relates to the operation of a Level I Trauma Center.

3) Any financial statements or any other documentation to support a financial need related to the funding formula set forth in this Section.

b) Criteria for Level I Trauma Center Grants.
Level I Trauma Center Grants shall be awarded using the following formula which first allocates the appropriated funds by Trauma Region and then within a Trauma Region divides the funds for individual Level I Trauma Centers. The formula shall be implemented using Illinois Trauma Registry data for the most recently available two quarters or estimated trauma data using existing sources of data such as individual trauma centers, Hospitals of the Illinois Health Care Cost Containment Council when the Illinois Trauma Registry data is not available. For the purpose of this Section, Trauma Region shall mean the Trauma Regions established by the Department in which Level I Trauma Centers are located and Trauma cases are those which represent patients admitted to a trauma service with an Injury Severity Score (ISS) of 9.0 or above.

1) The appropriated funds shall be allocated by Trauma Region utilizing the following formula for proportional division by Trauma Region: The total number of Medicaid Trauma Cases plus the total number of Uninsured Trauma Cases at the Level I Trauma Centers in a Trauma Region divided by the total number of Medicaid Trauma Cases plus the total number of Uninsured Trauma Cases at the Level I Trauma Centers in the State. The resulting portion is multiplied by the amount of money available.

2) In determining the division of the appropriated funds allocated by Trauma Region in accordance with subsection (b)(1) to individual Level I Trauma Centers, the Department will divide the available funds in two portions which shall be allocated in accordance with the following two part funding formula:

A) The first portion shall be at least 75 percent of the amount available for that region and shall be awarded to individual hospitals based upon the multiplication of the available funds by the total number of Medicaid Trauma Cases plus the total number of Uninsured Trauma Cases at individual Level I Trauma Centers in the Trauma Region divided by the total number of Medicaid Trauma Cases plus the total number of Uninsured Trauma Cases at the Level I Trauma Centers in the Trauma Region.

B) The second portion shall be no more than 25 percent of the amount available for that region and shall be awarded to individual hospitals based upon consideration of the following criteria:

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i) Medicaid Trauma Cases plus Uninsured Trauma Cases of specific Level I Trauma Centers divided by the Total Number of Trauma Cases at the specific Level I Trauma Center.

ii) Trauma Region needs for continuing and additional services based upon an assessment of any documentation submitted including recommendations from regional planning bodies and local health departments.

iii) Extreme financial hardship based upon an assessment of any documentation submitted, such as financial statements, a description of financial pressures because of volume and severity, description of financial effect of the Level I designation and any study of Level I trauma costs.

C) Grants shall be awarded from each portion of the appropriated funds according to the formulas set forth in subsections (b)(2)(A) and (B). In each Trauma Region, this formula shall result in a least one Level I Trauma Center receiving a grant of $50,000. If the formula does not result in at least one Level I Trauma Center in each Trauma Region receiving a grant of $50,000, then the Level I Trauma Center which would receive the most under the formula in the region will be allocated $50,000 and the formula will be reapplied for the distribution of the remaining funds.

c) Grant Period.
The Department will conduct one grant period for these grants with the available funds which shall commence on a specified date each year. All applications shall be due on the date set by the Department. Notification of the grant awards shall take place within 4 to 6 weeks of the application deadline.

d) Grant Requirements.
All grantees shall enter into a grant agreement with the Department. This grant agreement shall include the grantee's assurances that the grantee will maintain its designation as a Level I Trauma Center for the grant period and submit the Trauma Registry data required under Section 540.120 directly to the Department. Any grantee that fails to maintain its designation or submit the Trauma Registry data required under Section 540.120 shall refund all funds granted for that grant period.

(Source: Added at 14 Ill. Reg. 19041, effective December 15, 1990)

Section 540.220 Trauma Center Fund

a) *The Department shall distribute 97.5% of 50% of the moneys deposited into the Trauma Center Fund, a special fund in the State Treasury, to Illinois hospitals that are currently designated as trauma centers. No moneys may be distributed to a trauma center located outside of the*

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State. (Section 14.1 of the Act.)

b) *The moneys in the fund shall be allocated proportionally to each trauma region so that the trauma region receives the money collected from within its region for violations of laws or ordinances regulating the movement of traffic.* (Section 14.1 of the Act)

1) The total amount of funds per trauma region will be based on the money received from the counties in that region.

A) If a county has more than one trauma region, the moneys received from that county shall be divided among the regions based on each region's share of the county's trauma cases.

B) Trauma regions that have developed joint trauma region plans to enable them to function as one region shall be treated as one region in the calculation.

2) At the beginning of each State fiscal year, the Department shall calculate a per trauma case allocation for each region, which shall be used to determine each trauma center's share of the funds collected during the previous State fiscal year.

A) Each trauma region's funds collected during the previous State fiscal year shall be divided by the region's total number of qualifying trauma cases from that year. The resulting number is the per trauma case allocation.

B) Each trauma center's total number of qualifying trauma cases during the previous State fiscal year shall be multiplied by its region's per trauma case allocation, to determine the trauma center's share of the funds collected during that fiscal year.

3) The Department shall distribute the previous State fiscal year's funds within 90 days after the beginning of the next fiscal year.

4) The Department may also distribute funds collected during a current State fiscal year. A trauma center's share would be determined by multiplying the number of its qualifying trauma cases in the current State fiscal year to date by its region's per trauma case allocation for the previous fiscal year.

c) For purposes of this Section, a 'qualifying trauma case' means a patient reported to the Illinois Trauma Registry who was either:

1) Admitted to the trauma center with an injury severity score (ISS) of 9 or greater; or

2) Treated in the trauma center and transferred.

(Source: Added at 18 Ill. Reg. 2620, effective February 10, 1994)

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Section 540.APPENDIX A A Request for Designation (RFD) Trauma Center

PART A

a) Please specify the level which your hospital is applying by putting "X" by the appropriate status.
   1) Level I _____
   2) Level II _____

b) If your hospital is applying for Level I status and it is discovered your facilities do not meet the standards, does your hospital wish to be considered for Level II status?
   1) Yes _____
   2) No _____

c) All requirements described or listed in this Request for Designation must be met and operational by the date of designation.

   1) Table of Organization
      Please construct a Table of Organization to show the administrative relationships among all departments in the hospital, especially as they relate to the trauma service. Please highlight the surgical subspecialties. In addition, please include a separate graph showing the structure of the trauma service.
      A) Board of Directors
      B) Chief Executive Officer
      C) Department of Surgery
      D) Department of Medicine
      E) Department of Radiology
      F) Department of Pathology
      G) Clinical Laboratory Service
      H) Emergency Department
      I) Trauma Service
      J) Rehabilitation Department

   2) Philosophy of the Trauma Service
      A Trauma Service requires the commitment of all services involved in the care of the victim of traumatic injury. Consequently, a Trauma Service should have a philosophy which guides its function. Please include a statement of philosophy and objectives for your Trauma Service.

   3) Flow Chart
      Please provide a description of the flow of the trauma patient from admission through discharge. Outline all providers who initiate patient care and the mechanism whereby the trauma team (list team members) responds to the Emergency Department and assumes responsibility for the patient. In addition, please provide your plan for dealing with rapid, consecutive, emergency admissions (not the multiple casualty incident plan).

   4) Describe the relationship between the emergency physicians and the trauma team. Who is in charge of the patient in the

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emergency room? At what point does the care of the patient switch from the emergency physician to the trauma team?

   5) If residents provide general surgery coverage, please provide the written policy that gives them the authority to immediately operate on the trauma patient. Please indicate the level of residents and policy for supervision by the appropriate medical staff member.

   6) Provide documentation of the trauma teams' prompt responsiveness for the trauma patient. This may be in the form of an emergency department log that includes time of notification from the pre-hospital providers, time of notification of the trauma team members, time or arrival of the patient, time of arrival of the trauma team members, time the patient leaves the emergency room, etc.

   7) Please describe the ICU coverage as required by the level of trauma center for which your hospital is applying.

   8) Please check whether your hospital provides in-house or by transfer agreement the following services. If your hospital uses transfer agreements for any of these, please provide a copy. Also provide a copy of the agreement with the pre-hospital provider that supplies transfer to other facilities.

	*Provide In-house	Transfer Agreement
A) Hemodialysis capability	_____	_____
B) Burn care unit	_____	_____
C) Spinal cord injury rehabilitation capability		_____

   9) Please describe your operating room staffing and their availability.

   10) Facility Characteristics
      Please include the following information for the most recent complete calendar year:
      A) Total Number of Beds
         i) Pediatric _____
         ii) Adult _____
      B) Number of Emergency Department Visits _____
      C) Number of Admissions
         - from Emergency Department _____
         - transferred from other hospitals _____
      D) Number of Beds
         - Intensive Care Unit _____
            1. Pediatric _____
            2. Adult _____
         - Critical Care Unit _____
            1. Pediatric _____
            2. Adult _____
         - Spinal Care Unit _____

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1. Pediatric _____
2. Adult _____
- Burn Care Unit _____
1. Pediatric _____
2. Adult _____

E)

i) Do you have a Trauma Service? Yes _____ No _____
ii) Do you have designated beds for trauma service patients? Yes _____ No _____
iii) If yes, how many beds? Yes _____ No _____
iv) Are trauma victims cared for on other services? Yes _____ No _____
v) Number of trauma admissions _____

F) Please attach a list of the traumatic operative cases performed (for the most recent complete month).

G) Disposition of major trauma patients.*
- transferred to other facilities _____
- expired _____
- discharged _____
- other _____

* "Major Trauma Patient" means a person who has sustained acute injury and by means of a standardized field triage criteria (anatomic, physiologic, and mechanism of injury) is judged to be at significant risk of mortality or major morbidity.

d) The following pages must be completed by the appropriate personnel and signed by those indicated at the bottom of each page. They must all be completed, signed and returned with the RFD.

1) Please provide your protocol for the priority use of radiology services for major trauma.

Date: _____

_____
Trauma Service Director

_____
Director of Radiology

2) Please include your protocol for use of laboratory services for the Trauma Services.

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Date: _____

_____
Trauma Service Director

_____
Director of Laboratory Services

3) Describe your blood banking capabilities and your procedures for obtaining large volumes of blood.

Date: _____

_____
Trauma Service Director

_____
Director of Hematology or Blood Bank

4) Education
Does your hospital provide internal programs for continuing education in trauma for the following groups:

A) Staff Physician Yes____ No____
B) Hospital Nursing Director Yes____ No____
C) Emergency Room Nursing Director Yes____ No____
D) Trauma Nurses Yes____ No____
E) Emergency Room Nurses Yes____ No____
F) Emergency Physicians Yes____ No____
G) EMT's Yes____ No____

Date: _____

_____
Trauma Service Director

_____
Chief of Medical Staff

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Medical Emergency Department Director

Emergency Room Nursing Director

5) Quality Assurance (please describe)
Morbidity and Mortality Review
A) Frequency of Activity:
B) Format of Activity:
C) Person-Department Responsible for Activity:
D) Policies for Corrective Action:
E) Personnel Invited (list groups, not individuals)

Date: _____

Trauma Service Director

Signature of Person Responsible
(with title)

6) Multidisiplinary Trauma Conference

	Yes	No
A) Occurs Monthly	_____	_____

B) Format of Activity:
C) Person-Department Responsible for Activity:
D) Policies for Internal Corrective Action:
E) Personnel Invited (list groups, not individuals)
i) In-house _____
ii) Open _____

Date: _____

Trauma Service Director

Signature of Person Responsible

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(with title)

7) Trauma Nursing Audit

	Yes	No
A) Occurs Monthly	_____	_____

B) Format of Activity:
C) Person-Department Responsible for Activity:
D) Policies for Internal Corrective Action:
E) Personnel Invited (list groups, not individuals)
i) In-House _____
ii) Open _____

Date: _____

Trauma Service Director

Director of Nursing

8) Letter of Commitment
This complete RFD has been reviewed and approved.

Date: _____

Chief Executive Officer

Date: _____

Trauma Service Director

Date: _____

Chief of Medical Staff

Date: _____

Director of Nursing

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PART B

NOTE: If your hospital is not applying for Level I status, please leave Part B blank and proceed to Part C.

LEVEL I REQUIREMENTS

	MEET REQUIREMENTS	DO NOT MEET REQUIREMENT
1) Trauma Surgeon as specified in Section 540.70(b)	_____Yes	_____No
2) Trauma Service as specified in Section 540.70(c)	_____Yes	_____No
3) Provision of the following surgical services within thirty minutes:		
A) Cardiothoracic	_____Yes	_____No
B) Neurosurgical	_____Yes	_____No
C) Obstetrics	_____Yes	_____No
D) Orthopedic	_____Yes	_____No
E) Reimplantation	_____Yes	_____No
F) Vascular	_____Yes	_____No
G) Opthalmologic	_____Yes	_____No
H) Oral-Dental	_____Yes	_____No
I) Otorhinolaryngologic	_____Yes	_____No
J) Plastic-Maxillofacial	_____Yes	_____No
K) Urologic	_____Yes	_____No
L) Pediatric general surgery	_____Yes	_____No
4) Trauma Center providing the following non-surgical services:		
A) Emergency Medicine staffed as in Section 540.70(e)(1).	_____Yes	_____No
B) Anesthesiology staffed as specified in Section 540.70(e)(2).	_____Yes	_____No
C) Radiology staffed as specified in Section 540.70(e)(3).	_____Yes	_____No
D) Intensive Care Medicine Unit Staffed as specified in Section 540.70(e)(4)(A) and B).	_____Yes	_____No
E) Intensive Care Medicine Unit providing the following equipment twenty-four hours a day:		
i) Airway control and ventilatin devices	_____Yes	_____No
ii) Oxygen source with concentration controls	_____Yes	_____No
iii) Cardiac emergency cart	_____Yes	_____No
iv) Temporary transvenous	_____Yes	_____No
v) Electrocardiograph-oscilloscope-defibrillator	_____Yes	_____No
vi) Cardiac output monitoring	_____Yes	_____No
vii) Electronic pressure monitoring	_____Yes	_____No
viii) Mechanical ventilator respirators	_____Yes	_____No
ix) Patient weighing devices	_____Yes	_____No
x) Pulmonary function measuring devices	_____Yes	_____No
xi) Temperature control devices	_____Yes	_____No
xii) Drugs, intravenous fluids, and supplies	_____Yes	_____No
xiii) Intracranial pressure monitoring devices	_____Yes	_____No
xiv) Temporary pacemaker	_____Yes	_____No
xv) Intra-acrtic ballon pump capability	_____Yes	_____No
F) Laboratory providing the following twenty-four hours a day in-house:		
i) Standard analysis of blood, urine, and other body fluids	_____Yes	_____No
ii) Blood typing and cross-matching	_____Yes	_____No
iii) Coagulation studies	_____Yes	_____No
iv) Comprehensive blood bank or access to a community central blood banks and adequate hospital storage facilities	_____Yes	_____No
v) Blood gases and pH determinations	_____Yes	_____No
vi) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a twenty-four hour per day basis	_____Yes	_____No
vii) Drug and alcohol screening	_____Yes	_____No
G) Cardiology services available in sixty minutes	_____Yes	_____No
H) Internal Medicine services available in sixty minutes	_____Yes	_____No
I) Neuroradiology staffed as specified in Section 540.70(e)(8)	_____Yes	_____No
J) Pediatric services available in sixty minutes	_____yes	_____No

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K) Postanesthetic recovery room twenty-four hours a day _____Yes _____No
L) Acute hemodialysis capability twenty-four hours a day or a transfer agreement _____Yes _____No
M) Burn center staffed by Registered Nurses trained in burn care twenty-four hours a day or a transfer agreement _____Yes _____No
N) Acute spinal cord injury management twenty-four hours a day or a transfer agreement _____Yes _____No
O) Reimplantation service within thirty minutes or a transfer agreement _____Yes _____No

5) Trauma Center staffing requirements
A) Emergency Department Director that is an American Board of Emergency Medicine certified physician _____Yes _____No
_____Yes _____No
B) Nurses in charge in each shift in the Emergency Department and the Trauma Service meeting the requirements as specified in Section 340.7(f)(2) _____Yes _____No
C) Operating room staffed in-house & available twenty-four hours a day _____Yes _____No

6) Trauma Center Equipment
A) Air by control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen, and mechanical ventilator _____Yes _____No
B) Suction device _____Yes _____No
C) Electrocardiograph-oscilloscope defibrillator _____Yes _____No
D) Apparatus to establish central venous pressure monitoring _____Yes _____No
E) All standard intravenous fluids and administrative devices, as specified in 340.730(g)(5) _____Yes _____No
F) Sterile surgical sets of procedure standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, thoracostomy, and cut down _____Yes _____No
G) Gastric lavage equipment _____Yes _____No
H) Drugs and supplies necessary for emergency care _____Yes _____No
I) X-ray and CAT scan capability, 24 hour coverage by inhouse technicians _____Yes _____No
J) Spinal immobilization equipment _____Yes _____No
K) Temporary pacemaker _____Yes _____No
L) Specialized pediatric resuscitation cart in the Emergency Area _____Yes _____No

7) Helicopter landing capabilities approved by State & federal authorities _____Yes _____No
8) Procedure for performing medical audits of its trauma services. _____Yes _____No
9) Micro Soft Disc Operating System (MS-DOS), IBM Compatible microcomputer with a hard disk (minimal capacity of 10 megabytes) that is available to the Trauma Service. _____Yes _____No

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PART C

LEVEL II REQUIREMENTS

	MEET REQUIREMENTS	DO NOT MEET REQUIREMENT
1) Trauma Surgeon as specified in Section 340.80(b)	_____Yes	_____No
2) Trauma Service as specified in Section 340.80(c)	_____Yes	_____No
3) Provision of the following surgical services within sixty minutes:	_____Yes	_____No
A) Cardiothoracic	_____Yes	_____No
B) Obstetrics	_____Yes	_____No
C) Orthopedic	_____Yes	_____No
D) Urologic	_____Yes	_____No
4) Provision of the following surgical services within sixty minutes or by transfer agreement:		
A) Neurologic	_____Yes	_____No
B) Ophthalmologic	_____Yes	_____No
C) Oral-Dental	_____Yes	_____No
D) Otorhinolaryngologic	_____Yes	_____No
E) Reimplantation	_____Yes	_____No
F) Plastic maxillofacial	_____Yes	_____No
5) Trauma Center providing the following non-surgical services:		

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A) Emergency Medicine staffed as specified in Section 540.80(f)(1) _____Yes _____No
B) Anesthesiology staffed as specified in Section 540.80(f)(2) _____Yes _____No
C) Laboratory providing the following twenty-four hours a day in-house:
  i) Standard analysis of blood, urine, and other body fluids _____Yes _____No
  ii) Blood typing and cross matching _____Yes _____No
  iii) Coagulation studies _____Yes _____No
  iv) Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities _____Yes _____No
  v) Blood gases and pH determinations _____Yes _____No
  vi) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a twenty-four hour per day basis _____Yes _____No
  vii) Drug and alcohol screening _____Yes _____No
D) Radiology staffed as specified in Section 540.80(f)(4) _____Yes _____No
E) Cardiology provided within sixty minutes _____Yes _____No
F) Internal Medicine provided within sixty minutes _____Yes _____No
G) Postanesthetic recovery room staffed & available within thirty minutes _____Yes _____No
H) Intensive Care Medicine Unit having available the following:
  i) A physician credentialed by the hospital and available within thirty minutes _____Yes _____No
  ii) Registered Professional Nurses twenty-four hours a day in the Intensive Care Unit _____Yes _____No
  iii) The following equipment twenty-four hours a day in-house:
    a) Airway control and ventilation devices _____Yes _____No
    b) Oxygen source with concentration controls _____Yes _____No
    c) Cardiac emergency cart _____Yes _____No
    d) Temporary transvenous pacemaker _____Yes _____No
    e) Electrocardiograph-oscilloscope defibrillator _____Yes _____No
    f) Pulmonary function measuring devices _____Yes _____No
    g) Temperature control devices _____Yes _____No
    h) Drugs, intravenous fluids, and supplies _____Yes _____No
    i) Temporary pacemaker _____Yes _____No
    j) Mechanical ventilator-respirator _____Yes _____No
    k) Patient weighing devices _____Yes _____No
I) Pediatrics provided within sixty minutes _____Yes _____No
J) Acute hemodialysis capability twenty-four hours a day or a transfer agreement _____Yes _____No
K) Burn Center staffed by Registered Nurses trained in burn care twenty-four hours a day or a transfer agreement _____Yes _____No
L) Acute spinal cord injury management twenty-four hours a day or a transfer agreement _____Yes _____No

6) Trauma Center Staffing Requirements
A) Emergency Department Director that meets the qualifications as specified in Section 540.80(g)(1) _____Yes _____No
B) Registered Nurses in charge in each shift in the Emergency Department and Trauma Service meeting the requirements as specified in Section 540.80(g)(2) _____Yes _____No
C) Operating room staffed and available within thirty minutes _____Yes _____No

7) Trauma Center Equipment
A) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen and

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	mechanical ventilator	_____Yes	_____No
B)	Suction device	_____Yes	_____No
C)	Electrocardiograph-oscilloscope defibrillator	_____Yes	_____No
D)	Apparatus to establish central venous pressure monitoring	_____Yes	_____No
E)	All standard intravenous fluids and administration devices, as specified in 540.320(b)(5)	_____Yes	_____No
F)	Sterile surgical sets of procedures standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, thoracostomy, and cut down	_____Yes	_____No
G)	Gastric lavage equipment	_____Yes	_____No
H)	Drugs and supplies necessary for emergency care	_____Yes	_____No
I)	X-ray and CAT scan capability, staffed and available within thirty minutes	_____Yes	_____No
J)	Spinal immobilization equipment	_____Yes	_____No
K)	Temporary pacemaker	_____Yes	_____No
L)	Specialized pediatric resuscitation part in the Emergency Area	_____Yes	_____No
8)	Helicopter landing capabilities approved by State & federal authorities	_____Yes	_____No
9)	Procedure for performing medical audits of its trauma service	_____Yes	_____No
10)	Written protocols for:		
A)	Treatment of trauma patients in the Trauma Center	_____Yes	_____No
B)	Transfer of trauma patients to the Level I Trauma Center serving the Trauma Region or a more specialized level of care	_____Yes	_____No
11)	Micro Soft Disc Operating System (MS-DOS), IBM Compatible microcomputer with a hard disk minimal capacity of 10 megabytes that is available to the Trauma Service	_____Yes	_____No

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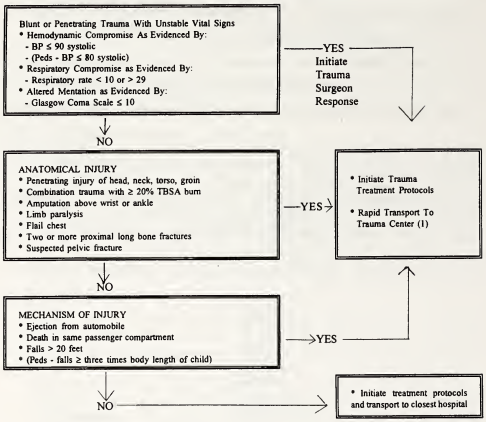
Section 540.APPENDIX B Minimum Trauma Field Triage Criteria



(1) > 25 minutes from Trauma Center, transport to nearest affiliate trauma hospital.
> 30 minutes from Trauma Center or affiliate trauma hospital, transport to nearest hospital.

Adapted from Trauma Care System Guidelines, ACEP, 1992, and Resources for

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Optimal Care of the Injured Patient, ACS, 1993. It is expected that each Region will expand upon this minimal triage set based on individual assessments, resources, and outcomes.

(Source: Added at 19 Ill. Reg. 13417, effective September 15, 1995)

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NOTICE OF PROPOSED REPEALER

1) Heading of the Part: Trauma Nurse Specialist Course Code

2) Code Citation: 77 Ill. Adm. Code 542

3)

Section Numbers:	Proposed Action:
542.10	Repealer
542.20	Repealer
542.30	Repealer
542.40	Repealer
542.50	Repealer
542.60	Repealer
542.70	Repealer
542.80	Repealer
542.90	Repealer
542.100	Repealer

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act, as amended by P.A. 89-177, effective July 19, 1995 [210 ILCS 50]

5) A Complete Description of the Subjects and Issues Involved: These rules implement provisions of the Emergency Medical Services (EMS) Systems Act that authorize the Department to set requirements by rule for continuing education for professional nurses. Public Act 89-177 (effective July 19, 1995) repealed substantial portions of the Act and established new provisions in place of those repealed. New rules are needed to implement the revised Act. The Department plans to adopt replacement rules in conjunction with this Repealer. The rule will be included in 77 Ill. Adm. Code 515 (Emergency Medical Services Code).

6) Will this Rulemaking Replace an Emergency Rule Currently in Effect? No

7) Does this Rulemaking Contain an Automatic Repeal Date? No

8) Does this Rulemaking Contain Any Incorporations By Reference? No

9) Are there any other Proposed Amendments Pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State Mandate.

11) Time, Place, and Manner in which Interested Persons May Comment on this Rulemaking: Interested persons may present their comments concerning these rules by writing within 45 days after this issue of the *Illinois Register* to:

Ms. Gail M. DeWitt
Division of Governmental Affairs
Illinois Department of Public Health

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535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
(217)782-5187

These rules may have an impact on small businesses. Any small business commenting on these rules shall indicate their status as such, in writing, in their comments.

12) Initial Regulatory Flexibility Analysis:

A) Type of Small Businesses, Small Municipalities and Not-for-Profit Corporations Affected: None

B) Reporting, Bookkeeping or Other Procedures Required for Compliance: None

C) Types of Professional Skills Necessary for Compliance: None

13) Regulatory agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Repealer begins on the next page:

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NOTICE OF PROPOSED REPEALER

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 542
TRAUMA NURSE SPECIALIST COURSE CODE (REPEALED)

Section
542.10 Definitions
542.20 Incorporated Materials
542.30 TNS Training Site Requirements
542.40 Regional Nurse Coordinator
542.50 Admission Requirements
542.60 Curriculum
542.70 Clinical Experience
542.80 Testing
542.90 Testing Option
542.100 TNS Course Completion

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act (Ill. Rev. Stat. 1987, ch. 111 1/2, pars. 5501 et seq.).

SOURCE: Adopted at 13 Ill. Reg. 3086, effective March 1, 1989; repealed at 20 Ill. Reg. _____, effective _____.

Section 542.10 Definitions

For the purposes of this part:

"Act" or "EMS Act" means the Emergency Medical Services (EMS) Systems Act, Ill. Rev. Stat. 1987, ch. 111 1/2, pars. 5501 et seq.

"Advanced Life Support-Mobile Intensive Care (ALS-MICU(ALS)" means an advanced level of pre-hospital and inter-hospital emergency care that includes basic life support functions, including Cardiopulmonary Resuscitation (CPR) plus Cardiac monitoring, cardiac defibrillation, Telemetered Electrocardiography, Administration of Antiarrhythmic agents, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures(initiated for the treatment of real or potential acute life threatening conditions under the direction of a physician licensed to practice medicine in all of its branches or a qualified registered professional nurse, and where authorized by the project medical director in an Illinois Department of Public Health approved advanced life support system. (Section 4.01 of the Act).

"Department" means the Department of Public Health, State of Illinois.

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(Section 4.09 of the Act).

"Emergency" means a condition or situation in which an individual declares a need for immediate medical attention or when that need is declared by emergency medical personnel or a public safety official. (Section 4.11 of the Act).

"Hospital" has the meaning ascribed to it in the hospital licensing act (Ill. Rev. Stat. 1987, ch. 111 1/2, par 142 et seq.). (Section 4.04 of the Act).

"Regional Nurse Coordinator" means the registered professional nurse employed by a TNS Training Site to plan, coordinate, implement and evaluate the TNS course and TNS Program Activities.

"Registered Nurse" "Registered Professional Nurse" means a person who is licensed as a professional nurse under the Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1987, ch. 111, pars. 3401 et seq.).

"Trauma" means any severe injury which involves single or multiple organ systems such injuries which are potentially or immediately life or limb threatening. (Section 4.26 of the Act).

"Trauma Nurse Specialist Course" or "TNS Course" means a standardized program for training Registered Nurses in trauma patient care, developed and sponsored by the Department and conducted by hospitals authorized by the Department. A Registered Nurse who has successfully completed the course receives a certificate of completion from the Department.

"Trauma Nurse Specialist Training Site" or "TNS Training Site" means a hospital which has been approved by the Department, pursuant to the provisions of this Part, to conduct a TNS course.

Section 542.20 Incorporated Materials

a) The following regulations, standards and statutes are incorporated or referenced in this Part:
b) State of Illinois Statutes:
   1) Hospital Licensing Act (Ill. Rev. Stat. 1987, ch. 111 1/2, pars. 142 et seq.). (See Section 542.10).
   2) Illinois Nursing Act of 1987 (Ill. Rev. Stat. 1987, ch. 111, pars. 3501 et seq.). (See Sections 542.120(a)).

Section 542.30 TNS Training Site Requirements

a) Trauma Nurse Specialist Courses shall be conducted only at hospitals which have been designated by the Department as TNS Training Sites.

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b) The Department shall designate TNS Training Sites based upon regional needs for course availability, the trauma educational and clinical capabilities of interested hospitals, prior Department approval of a hospital as a TNS Training Site, and participation in an EMS System.
c) Any hospital seeking designation as a TNS Training Site must submit an application on a form provided by the Department.

Section 542.40 Regional Nurse Coordinator

The Chief Executive Officer of the hospital designated as a TNS Training Site shall appoint and endorse in writing to the Department a Regional Nurse Coordinator to plan, coordinate, implement and evaluate the TNS Course, and TNS Program Activities who meets the following requirements:
a) Is a registered professional nurse licensed under the Illinois Nursing Act;
b) Is employed by the TNS Training Site;
c) Has at least three (3) years of experience as a registered professional nurse in an emergency department or critical care setting;
d) Has a current cardiopulmonary resuscitation (CPR) Card;
e) Holds a Certificate of TNS Course Completion issued by the Department or its equivalent as provided in Section 542.120(d) of this part;
f) Has a minimum of 50 hours of teaching experience in emergency/critical care nursing courses;
g) Is currently certified as an Advanced Cardiac Life Support (ACLS) instructor or provider by the American Heart Association.

Section 542.50 Admission Requirements

The Regional Nurse Coordinator shall admit to the TNS Course only those individuals who have met the following requirements:
a) Is currently licensed as a registered nurse in or out of the State of Illinois, as verified by the submission of a photocopy of the official document showing the license number and expiration date;
b) Has at least one (1) year of experience as a registered professional nurse in an emergency department of critical care setting;
c) Has a current CPR card;
d) Has completed a basic electrocardiography (EKG) course. Such a course includes instruction in the recognition of a normal EKG pattern on a monitor as well as the recognition of basic life threatening dysrhythmias and treatments.

Section 542.60 Curriculum

The TNS course shall include at last eighty (80) hours of didactic sessions. The course content shall include but not be limited to the following topics:
a) EMS Concepts,
b) Stabilization and Transportation of the critically ill or injured,

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c) Assessment and Management of the traumatized patient,
d) Maxillofacial Trauma,
e) Ocular Trauma,
f) Neurological Anatomy and Physiology Assessment,
g) Head Injury,
h) Spinal Injury,
i) Cardiopulmonary Trauma,
j) Adjuncts for Airway Control and Ventilation,
k) Acid Base-Balance and ABGs,
l) Abdominal Trauma,
m) Genitourinary Trauma,
n) Trauma in Pregnancy,
o) Musculoskeleal Trauma,
p) Thermal Injuries,
q) Wound Management and Infection Control,
r) Fluid and electrolytes,
s) Pathogenesis of shock syndrome,
t) Pediatric Trauma,
u) Child Abuse,
v) Organ procurement,
w) Human response to crisis and,
x) Legal Issues.

Section 542.70 Clinical Experience

The TNS Course shall include twenty-four (24) hours of supervised clinical experience distributed among the following areas:

a) Pre-hospital (riding as an observer on an EMS vehicle),
b) Critical care (direct patient care of a post-trauma victim), and
c) Emergency Department (direct patient care of a critically injured patient).

Section 542.80 Testing

a) A written pre-test consisting of a minimum of 100 multiple-choice questions developed by the Regional Nurse Coordinators and approved by the Department shall be administered on the first day of class. The Regional Nurse Coordinators develop the questions based upon the topic outlines and objectives of the curriculum. The Department reviews the questions with the same topic outlines and provides changes as necessary or approves the questions.
b) A minimum of two quizzes developed and provided by the Regional Nurse Coordinator shall be administered. The student must achieve a total average score of 80% or above for the quizzes. A student whose total average quiz score is below 80% shall be given one opportunity to retake the lowest scoring quiz.
c) A Practical Examination shall be administered at the conclusion of the didactic sessions and clinical experience. The Practical Examination

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shall consist of a simulated trauma patient assessment station at which the student will evaluate and stabilize a simulated critically injured patient.
1) The student shall have a maximum of ten (10) minutes to evaluate and stabilize the patient.
2) The student shall be rated on Primary Patient Assessment, Secondary Patient Assessment, Management, Stabilization and Supervision and Leadership, in accordance with the Trauma Nurse Specialist Course Practical Examination Grading Form developed and provided by the Department.
3) A student who receives a failing grade on the Practical Examination shall be given one opportunity to repeat the Practical Examination. A failing grade is defined as failure to attain 19 out of 25 points overall and/or failure to pass all life saving techniques asterisked on the Clinical Examination Grading Form.
4) The Regional Nurse Coordinator may designate other individuals to assess student performance in the Practical Examination when the class size exceeds eight (8) students. Such individuals shall meet the same qualifications as described in Section 542.40 with the exception of 5).
d) A student who has successfully completed the didactic sessions and clinical experience shall be eligible to take the final examinations. The final examination is developed by the Regional Nurse Coordinators using the objectives and topics of the TNS Curriculum. The Department approves the examination based upon the objectives and topic outlines.
e) A final written examination shall be administered consisting of 150 multiple choice questions developed by the Regional Nurse Coordinators and approved by the Department. A score of 80% or above shall be a passing grade.
1) A student shall be given on opportunity to retake the final written examination within ten (10) days of the original examination date.
2) The Regional Nurse Coordinator shall extend the ten (10) day retake period on an individual basis, for reasons of a death in the student's family, illness or injury to the student or student's family.
f) Each TNS site shall offer a minimum of two (2) Practical and final written examinations per year. Additional examinations shall be offered based upon regional needs.

Section 542.90 Testing Option

a) Any individual who has met the admission requirements provided in Section 542.50 of this Part has the option of taking the TNS Practical Examination and final written examination without having completed the didactic sessions, clinical experience and quizzes.
b) The individual must file a request for the testing option with the TNS

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Training Site at least thirty (30) days prior to the scheduled Practical Examinations.

Section 542.100 TNS Course Completion

a) Successful completion of a TNS Course requires a score of 80% or above on the final written examination and a passing grade on the Practical Examination.

b) As soon as the examination scores have been determined, the Regional Nurse Coordinator shall submit to the Department the names and addresses of the individuals who have successfully completed the TNS Course.

c) The Department shall issue Certificates of TNS Course Completion to the Regional Nurse Coordinators to be signed and distributed to those individuals who have successfully completed a TNS course.

d) A Department-issued certificate of completion for a Department-sponsored trauma nurse specialist course completed prior to the adoption of this Part shall be recognized as equivalent to the Certificate of TNS Course Completion issued pursuant to this Part."

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1) Heading of the Part: Assessment for Determining Eligibility and Rehabilitation Needs

2) Code Citation: 89 Ill. Adm. Code 553

3)

Section Numbers:	Proposed Action:
553.10	Amendments
553.20	Amendments
553.40	Amendments
553.50	Amendments
553.70	Amendments
553.80	Amendments
553.90	Amendments
553.100	Amendments
553.105	Amendments
553.110	Amendments
553.120	Amendments
553.140	Amendments

4) Statutory Authority: Implementing and authorized by Section 3 of the Disabled Persons Rehabilitation Act (20 ILCS 2405/3).

5) A Complete Description of the Subjects and Issues Involved: DORS is modifying its eligibility determination process so that accurate, timely determinations can be made for individuals seeking services through the Vocational Rehabilitation Program. These changes are required so that DORS can make accurate determinations within the 60 day period mandated by the Rehabilitation Act of 1973, as amended (29 U.S.C. 701-796i).

6) Will this rulemaking replace any emergency rulemaking currently in effect? Yes

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending on this Part? Yes

Section Numbers	Proposed Action	Illinois Register Citation
553.130	Amendments	20 Ill. Reg. 10305, 08/02/96

10) Statement of Statewide Policy Objectives: This is not applicable to this Rulemaking.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning these rules within 45 days after this issue of the *Illinois*

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Register. All requests and comments should be submitted in writing to:

Ms. Susan Warrner, Manager
Regulations and Procedures Division
Department of Rehabilitation Services
P.O. Box 19429
Springfield, IL 62794-9429
(217) 785-3396
TTY: (217) 785-9301

If because of physical disability you are unable to put comments into writing, you may make them orally to the person listed above.

12) Initial Regulatory Flexibility Analysis: The Department has determined that this rulemaking will not affect small businesses.

13) Regulatory Agenda in which this rulemaking was summarized: This rule was not included on either of the 2 most recent agendas because: This change was not anticipated at the time of the January Regulatory Agenda.

The full text of the Proposed Amendment(s) begins on the next page:

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF REHABILITATION SERVICES
SUBCHAPTER c: VOCATIONAL REHABILITATION

PART 553
ASSESSMENT FOR DETERMINING ELIGIBILITY AND REHABILITATION NEEDS

Section
553.10 General Applicability
553.20 Basis for the Determination of Eligibility
553.30 Presumption of Benefit from Vocational Rehabilitation Services
553.35 Services to Non-United States Citizens
553.40 Eligibility Determination Time Frames
553.50 Outcome of the Eligibility Determination
553.60 Documentation of Eligibility Factors/Preliminary Assessment
553.70 Certification of Eligibility
553.80 Extended Evaluation
553.90 Outcome of Extended Evaluation
553.100 ~~Comprehensive~~ Assessment of Rehabilitation Needs
553.105 Assistance in Attaining Necessary Financial Support
553.110 Outcome of the ~~Comprehensive~~ Assessment of Rehabilitation Needs
553.120 Change in Eligibility Status
553.130 Order of Selection
553.140 Criteria for Severe Disability and Most Severe Disability
553.150 Determination of Serious Limitation to Functional Capacities

AUTHORITY: Implementing and authorized by Section 3 of the Disabled Persons Rehabilitation Act [20 ILCS 2405/3].

SOURCE: Emergency rules adopted at 17 Ill. Reg. 11657, effective July 1, 1993, for a maximum of 150 days; adopted at 17 Ill. Reg. 20346, effective November 15, 1993; amended at 19 Ill. Reg. 1834, effective February 6, 1995; amended at 19 Ill. Reg. 10149, effective June 29, 1995; amended at 19 Ill. Reg. 15730, effective November 7, 1995; emergency amendment at 20 Ill. Reg. 10385, effective July 19, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. _____, effective August 16, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. _____, effective _____.

Section 553.10 General Applicability

The Rules contained in this Part are applicable to all customers ~~clients~~ of the Department of Rehabilitation Services' (DORS) Vocational Rehabilitation (VR) Program.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

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Section 553.20 Basis for the Determination of Eligibility

An individual shall be determined to be eligible to receive services through the VR Program if he she:

a) is an individual with a disability as defined in Section 7(8)(A) of the Rehabilitation Act of 1973 (29 USCA 701 et seq.), as amended (Act). Pursuant to the Act, to be an individual with a disability, an individual must have a physical or mental impairment which results in a substantial impediment to employment, and who can benefit from vocational rehabilitation services in terms of an employment outcome; and

b) requires VR services to prepare for, enter, engage in, or retain gainful employment; and

c) meets the priority for services established under DORS' Order of Selection in Section 553.100.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.40 Eligibility Determination Time Frames

After receiving a completed application for VR services, DORS shall make an eligibility determination and determine the individual's priority to receive services under the Order of Selection within a reasonable time period, not to exceed 60 calendar days from the date the individual applies for services unless:

a) DORS notifies the individual that exceptional and unforeseen circumstances beyond DORS control preclude DORS from completing a timely determination and the individual agrees to an extension; or

b) DORS determines, on the basis of the criteria set forth at 89 Ill. Adm. Code 553.30, that a period of extended evaluation is necessary to document whether or not the individual can be expected to benefit from VR services in terms of an employment outcome or to identify employability for the customer.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.50 Outcome of the Eligibility Determination

Prior to the end of the eligibility determination period (i.e., 60 days), one of the following must occur:

a) the customer has been ~~client-is~~ determined to be eligible to receive VR services and has a disability which will allow services to be provided under the Order of Selection. The customer will then undergo an Assessment of Rehabilitation Needs pursuant to Section 553.100 of this Part; ~~based-on-the-criteria--set--forth--in--Section--553.20---A Certification--of--Eligibility--(89--Ill--Adm--Code-553.53)-shall-be completed-and-the-individual-shall-enter-a-Comprehensive-Assessment-of Rehabilitation-Needs-to-the-extent-needed-by-the-individual---89---Ill Adm--Code-553.999);~~

b) the customer is determined eligible but not to have a disability which allows services to be provided under the Order of Selection. The customer will be offered the option to have his/her name placed in a waiting list to wait until services can be provided to the priority category established under the Order of Selection or to have his/her case closed;

cb) an extended evaluation is determined necessary. A Certification of Extended Evaluation shall be completed and such an evaluation shall begin;

dc) the customer ~~client~~, because of lack of a disability ~~which-for-that individual-constitutes-or-results--in--a-substantial--impediment--to employment~~, is determined to be ineligible to receive services. A Certification of Ineligibility shall be completed and the individual's case closed;

ed) the customer's ~~client's~~ case is closed for reasons other than ineligibility (e.g., the customer ~~client~~ has refused services or further services from DORS, the customer ~~client~~ cannot be located); or

fe) the customer's ~~client's~~ case is closed as he/she is determined ineligible to receive services due to the fact he/she does not meet the required criteria (see 89 Ill. Adm. Code 553.20).

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF REHABILITATION SERVICES

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Section 553.70 Certification of Eligibility

At any time during the eligibility determination process, but no later than 60 days from the date of an individual's application for services except as provided in Section 553.40 of this Part, a Certification of Eligibility, per 89 Ill. Adm. Code 553.40, shall be completed unless extenuating circumstances exist and is agreed upon by the individual or a period of Extended Evaluation (89 Ill. Adm. Code 553.80) is determined to be necessary.

The Certification of Eligibility shall document the basis on which the customer ~~client~~ was determined to be eligible, including identification of the individual's disability, description of the individual's need for ~~assessed specifically-why-the--individual--is--in--need--of~~ VR services to reach an employment outcome, indication of the priority category to which the individual has been assigned under the Order of Selection and an outline of the services that are expected to be necessary to determine the individual's service needs during the ~~Comprehensive~~ Assessment of Rehabilitation Needs (89 Ill. Adm. Code 553.100).

(Source: Amended at 20 Ill. Reg. _____, effective _____)

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Section 553.80 Extended Evaluation

a) If, prior to the expiration of the 60 calendar day eligibility determination period, it is determined that sufficient evidence exists to justify the need for extended evaluation, a Certification of Extended Evaluation shall be completed and such an evaluation shall commence. The Certification of Extended Evaluation shall identify why a determination of eligibility could not be completed during the 60 calendar day eligibility determination period and specifically outline the services that are to be provided during extended evaluation to determine the individual's eligibility or ineligibility.

b) The sole purpose of the extended evaluation shall be to determine whether or not the individual can benefit from services in terms of a successful employment outcome and/or to identify employability. DORS may not deny the individual access to VR services, unless DORS can prove through clear and convincing evidence that the individual is incapable of benefitting from VR services in terms of a successful employment outcome.

c) The period of extended evaluation shall not exceed 18 months calculated from the date of the Certification of Extended Evaluation and shall be reviewed every 90 days.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.90 Outcome of Extended Evaluation

a) If, after a period of Extended Evaluation, the customer client is determined eligible, a Certification of Eligibility shall be prepared and the customer client shall begin an a Comprehensive Assessment of Rehabilitation Needs (see 89 Ill. Adm. Code 553.100).

b) If DORS, after a period of extended evaluation, is unable to demonstrate through clear and convincing evidence that the individual cannot benefit from VR services in terms of an employment outcome, he she shall be presumed to be able to benefit from services (89 Ill. Adm. Code 553.30) and shall be certified as eligible to receive VR services.

c) When clear and convincing evidence is in the case file documenting the individual is not capable of benefiting benefitting from VR services, certification of Ineligibility shall be completed, which includes a summary and rationale for the determination based on the information gathered during the period of extended evaluation.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.100 Comprehensive Assessment of Rehabilitation Needs

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a) If a customer client is determined eligible to receive VR services (89 Ill. Adm. Code 553.50(a)), the he she must undergo a a Comprehensive Assessment of Rehabilitation Needs (Comprehensive Assessment) shall be completed.

b) A major component of the Comprehensive Assessment shall be the determination of the employment goal. The goal shall involve the customer client and take his/her interests into consideration, as well as career counseling provided to and with the customer client by the counselor regarding labor market trends and training requirements. The employment goal chosen by the customer client should be supported by the counselor unless the Comprehensive Assessment clearly contraindicates the customer's client's choice.

c) The Comprehensive Assessment will include a review of existing and additional information as to the individual's career plan, unique strengths, resources, priorities, interests, and needs to determine the nature and scope of services necessary to ensure the individual a successful employment outcome in the area of his/her chosen goal.

d) The scope of the Comprehensive Assessment shall be limited to that which is necessary to identify the rehabilitation needs of the individual and to develop the Individualized Written Rehabilitation Program (IWRP) (89 Ill. Adm. Code 572) for the individual. To the maximum extent possible the information used shall be existing information and information available from the individual and, where appropriate, from the individual's family.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.105 Assistance in Attaining Necessary Financial Support

At the conclusion of the Comprehensive Assessment of Rehabilitation Needsby after the determination of a suitable vocational goal, if the customer client cannot be expected to be able to attain a successful employment outcome due to lack of financial resources and there are benefits for which the customer client can be expected to be eligible, the rehabilitation counselor/instructor must assist the customer client in making application for such benefits.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.110 Outcome of the Comprehensive Assessment of Rehabilitation Needs

a) When it is determined by the counselor that enough information has been gathered during the Comprehensive Assessment to adequately determine and plan the VR services necessary to ensure the individual a successful employment outcome in the area of his/her chosen employment goal, an a Comprehensive Assessment Summary shall be

completed by the counselor as part of the chronological record. The Comprehensive Assessment Summary shall identify, in detail, the specific impairments the individual has in obtaining his/her vocational goal, documentation of career counseling, consideration of the individual's unique strengths, resources, priorities, and interests needed to identify the nature and scope of services and the specific services that are expected to be necessary to assist the customer client in achieving his/her employment outcome.

b) The Comprehensive Assessment Summary must also include a statement addressing the severity of the individual's disability(ies) and addressing the individual's eligibility based on the Order of Selection (pursuant to Section 553.140).

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.120 Change in Eligibility Status

If, at any time during the eligibility process or Comprehensive Assessment, the customer's client's condition changes to the extent he/she is no longer considered to have a disability, all case activity services shall cease, a Certificate of Ineligibility shall be completed and the customer's client's VR case closed. Customers Clients have the right to request a review of this determination under the procedures of 89 Ill. Adm. Code 510-Appeals and Hearings.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

Section 553.140 Criteria for Severe Disability and Most Severe Disability

a) Criteria for determining that the individual has a severe disability or a most severe disability must be in the individual's VR case file, stated and justified in the Assessment Summary (89 Ill. Adm. Code 553.70 and 89 Ill. Adm. Code 553.110) based on the following information.

b) To be considered an individual with a most severe disability in determining priority for services under the Order of Selection (Section 553.130) in this Part, the individual must meet all of the criteria listed in subsection (c), below, with the exception that the customer's disability must seriously limit three or more of the functional capacities, as listed in Section 553.150 of this Part.

c) To be considered an individual with a severe disability to determine priority of services under the Order of Selection (Section 553.130), he/she must have a disability which is determined by the rehabilitation counselor/instructor to meet all four of the following criteria:

1) The severe disability seriously limits at least two one-or-more of the individual's functional capacities, as listed in Section 553.150 of this Part.

2) The individual has a disability or combination of disabilities determined by an evaluation of rehabilitation potential to cause a substantial physical or mental impairment similar but not limited to the following list of disabilities:
   A) amputation,
   B) arthritis,
   C) autism,
   D) blindness,
   E) burn injury,
   F) cancer,
   G) cerebral palsy,
   H) cystic fibrosis,
   I) deafness,
   J) head injury,
   K) heart disease,
   L) hemiplegia,
   M) hemophilia,
   N) respiratory or pulmonary dysfunction,
   O) mental retardation,
   P) mental illness,
   Q) multiple sclerosis,
   R) muscular dystrophy,
   S) musculo-skeletal disorders,
   T) neurological disorders (including stroke and epilepsy,
   U) paraplegia,
   V) quadriplegia (and other spinal cord conditions),
   W) sickle cell anemia,
   X) specific learning disabilities, or
   Y) end stage renal failure disease.

3) Three or more VR services, which may include counseling and guidance services provided by the rehabilitation counselor/instructor, will be required to ensure the individual a successful employment outcome.

4) VR services will be required over an extended period of time. An extended period of time for the purposes of the VR Program is defined as 6 months or more.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Hotel Operators' Occupation Tax Act

2) Code Citation: 86 Ill. Adm. Code 480

3) Section Numbers: 480.110 — Proposed Action: Amendment

4) Statutory Authority: 35 ILCS 145

5) A Complete Description of the Subjects and Issues Involved: This rulemaking deletes the requirement that each hotel operator shall annually file an information return covering the preceding calendar year (or fiscal year if the operator files his federal income tax returns on the basis of a fiscal year).

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a state mandate, nor does it modify any existing state mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Gina Roccaforte
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794
(217) 782-6996

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Hotel operators.

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

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NOTICE OF PROPOSED AMENDMENTS

13) Regulatory Agenda on which this amendment was summarized: January, 1996

The full text of the Proposed Amendment(s) begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 480
HOTEL OPERATORS' OCCUPATION TAX ACT

Section
480.101 Nature, Rate and Scope of the Tax
480.105 Definitions
480.110 Registration and Returns
480.115 Books and Records
480.120 Penalties, Interest and Procedures
480.125 Claims to Recover Erroneously Paid Tax

AUTHORITY: Implementing the Hotel Operators' Occupation Tax Act [35 ILCS 145] and authorized by Section 39b19 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b19].

SOURCE: Adopted July 6, 1962; codified at 8 Ill. Reg. 8611; amended at 13 Ill. Reg. 10693, effective June 16, 1989; amended at 16 Ill. Reg. 3578, effective February 25, 1992; amended at 20 Ill. Reg. _____, effective _____.

Section 480.110 Registration and Returns

a) Registration
   1) It is unlawful for any person to engage in the business of renting, leasing or letting rooms in a hotel in this State without a Certificate of Registration from the Department of Revenue (Department).
   2) Any person who engages in such business is required to apply to the Department for a Certificate of Registration on a form which is prescribed by the Department, and which will be furnished on request. Upon receipt of the application to register in proper form, the Department will issue a Certificate of Registration to the applicant. Such Certificate of Registration must be publicly displayed.
   3) All the provisions of Subpart G of the Retailers' Occupation Tax Regulations (86 Ill. Adm. Code 130) (including the provisions concerning the furnishing of bond or other security by taxpayers to the Department, among other things), to the extent to which any such provision is not inconsistent with the ~~The~~ Hotel Operators' Occupation Tax Act [35 ILCS 145] ~~[111.--Rev.--Stat. 1987,--ch.--120,--par.--481b,31--et--seq.]~~ (the Act), and the Sections promulgated thereunder, shall apply to the tax collected pursuant to this Part. ~~are--incorporated--herein--by--reference--and--made--a part--of--this--Section.~~
b) Return and Payment of the Tax

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1) Except as provided hereinafter in this Section, on or before the last day of each calendar month, every person engaged in the business of renting, leasing or letting rooms in a hotel in this State during the preceding calendar month shall file a return with the Department, stating:
   A) The name of the operator;
   B) his residence address and the address of his principal place of business and the address of the principal place of business (if that is a different address) from which he engages in the business of renting, leasing or letting rooms in a hotel in this State;
   C) total amount of rental receipts received by him during the preceding calendar month from renting, leasing or letting rooms during such preceding calendar month;
   D) total amount of rental receipts received by him during the preceding calendar month from renting, leasing or letting rooms to permanent residents during such preceding calendar month;
   E) total amount of other exclusions from gross rental receipts allowed by the Act;
   F) gross rental receipts which were received by him during the preceding calendar month and upon the basis of which the tax is imposed;
   G) the amount of tax imposed, less a discount of 2.1% or $25.00 per calendar year, whichever is greater, which is allowed to reimburse the operator for the expenses incurred in keeping records, preparing and filing returns, remitting the tax and supplying data to the Department on request pursuant to this Act, if the return and payment are filed in accordance with this Section;
   H) the amount of penalty due, if any; and
   I) such other reasonable information as the Department may require.
2) If the operator's average monthly tax liability to the Department does not exceed $200.00, the Department may authorize his returns to be filed on a quarter annual basis, with the return for January, February and March of a given year being due by April 30 of such year; with the return for April, May and June of a given year being due by July 31 of such year; with the return for July, August and September of a given year being due by October 31 of such year, and with the return for October, November and December of a given year being due by January 31 of the following year.
3) If the operator's average monthly tax liability to the Department does not exceed $50.00, the Department may authorize his returns to be filed on an annual basis, with the return for a given year being due by January 31 of the following year.
4) Such quarter annual and annual returns, as to form and substance, shall be subject to the same requirements as monthly returns.

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5) Notwithstanding any other provision in the Act concerning the time within which an operator may file his return, in the case of any operator who ceases to engage in a kind of business which makes him responsible for filing returns under the Act, such operator shall file a final return under the Act with the Department not more than one month after discontinuing such business.

6) Where the same person has more than one business registered with the Department under separate registrations under the Act, such person shall not file each return that is due as a single return covering all such registered businesses, but shall file separate returns for each such registered business.

7) In his return, the operator shall determine the value of any consideration other than money received by him in connection with the renting, leasing or letting of rooms in the course of his business, and he shall include such value in his return. Such determination shall be subject to review and revision by the Department.

8) Where the operator is a corporation, the return filed on behalf of such corporation shall be signed by the president, vice-president, secretary or treasurer or by the properly accredited agent of such corporation.

9) The person filing the return shall, at the time of filing such return, pay to the Department the amount of tax due.

c) Annual Information Returns

~~1) In addition to any other return required by the Act, each operator shall annually file an information return covering the preceding calendar year (or fiscal year if the operator files his Federal income tax returns on the basis of a fiscal year). Such annual return shall be filed with the Department on a form prescribed by the Department not more than 30 days after the date set for the filing of such operator's Federal income tax return. Such annual return shall include a statement of gross receipts as shown by the operator's last Federal income tax return. If the total receipts of the business as reported in the Federal income tax return do not agree with the gross receipts reported to the Department for the same period, the operator shall attach to his annual information return a schedule showing a reconciliation of the two amounts and the reasons for the difference. The operator's annual information return to the Department shall also disclose payroll information of the operator's business during the year covered by such return and any additional reasonable information which the Department deems would be helpful in determining the accuracy of the monthly, quarterly or annual tax returns.~~

~~2) The foregoing requirements concerning the filing of an annual information return shall not apply to an operator who certifies on such annual information return that such operator is authorized to do business and is actually doing business in two or more states, provided that such certification is true.~~

~~3) The foregoing portion of this Section concerning the filing of an annual information return also shall not apply to an operator who is not required to file an income tax return with the United States Government.~~

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c)d) Special Reporting Problem Connected With Exclusion for Permanent Residents. The Act defines a "permanent resident" as a person who occupies or has the right to occupy a room for at least 30 consecutive days. It will not always be possible for a hotel to determine whether a guest is a "permanent resident" at the end of a particular reporting period. In such cases:

1) Where a guest has occupied a room for 30 consecutive days as of the end of a reporting period, no tax is due.

2) Where a guest has a binding contract for at least 30 days, no tax need be reported or paid; except that, if the contract is terminated before the end of the first 30 days, a tax should be paid for the period up to the time when the contract is terminated.

3) Where the hotel does not know whether a guest is a "permanent resident" at the end of the period for which a return is filed (because the first 30 days are not up), a tax should be paid. If the guest later stays for 30 days, the amount of rental for the first 30 days, or portion thereof, upon which a tax has already been paid, should be deducted in Item 3 on the return for the next month, and a schedule should be filed with the return explaining such deduction.

d)e) Gross Receipts or Gross Billing Basis of Reporting

1) At the beginning of a registration under the the Hotel Operators' Occupation Tax Act, the registrant may elect to file returns on the receipts basis (reporting, for the return period, only those receipts received during such return period), or the registrant may elect to file returns on the gross billing basis (reporting, for the return period, all rentals billed during the return period whether collected during such return period or not).

2) An operator may change from the gross billing basis to the gross receipts basis of reporting in tax returns without obtaining special permission from the Department. However, once an operator has commenced to file returns on the gross receipts basis, he may not change his method of reporting to the gross billing basis without first obtaining permission from the Department to make this change.

3) On the receipts basis of reporting, since the operator does not report and pay tax on receipts until he receives them, he would never have any occasion for taking a bad debt deduction on his returns. However, where the operator who is filing returns on the gross billing basis pays tax to the Department on a billing which later turns out to be a bad debt, and which is charged off

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on the operator's books as a bad debt for Federal income tax purposes, the operator may take a deduction for such bad debt on his Hotel Operators' Occupation Tax return to the Department. If such operator, after taking such bad debt deduction, should later realize a recovery thereon, he shall report and pay tax on the amount of such recovery when filing his return for the return period in which such recovery occurs.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

1) Heading of the Part: Salem Civic Center Retailers' Occupation Tax

2) Code Citation: 86 Ill. Adm. Code 690

3)

Section Numbers:	Proposed Action:
690.101	New Section
690.105	New Section
690.110	New Section
690.115	New Section
690.120	New Section
690.125	New Section
690.130	New Section

4) Statutory Authority: 20 ILCS 2505/39b19

5) A Complete Description of the Subjects and Issues Involved: This rulemaking implements Public Act 89-460, which authorizes the Salem Civic Center Authority to impose a Retailers' Occupation Tax in the City of Salem if approved by voters at referendum, imposed in one-quarter percent increments at a rate not to exceed 1%. Contains provisions concerning the nature of the tax, returns, etc.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a state mandate, nor does it modify any existing state mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Gina Roccaforte
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794
(217) 782-6996

12) Initial Regulatory Flexibility Analysis:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

A) Types of small businesses, small municipalities and not for profit corporations affected: Retailers in the City of Salem, Marion County.

B) Reporting, bookkeeping or other procedures required for compliance: Minimal

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: This rule was not included in either of the 2 most recent agendas because: It was unanticipated at the time of the regulatory agenda.

The full text of the Proposed Amendment(s) begins on the next page:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 690
SALEM CIVIC CENTER RETAILERS' OCCUPATION TAX

Section
690.101 Nature of the Salem Civic Center Retailers' Occupation Tax
690.105 Registration and Returns
690.110 Claims to Recover Erroneously Paid Tax
690.115 Jurisdictional Questions
690.120 Incorporation of Retailers' Occupation Tax Regulations by Reference
690.125 Penalties, Interest and Procedures
690.130 Effective Date

AUTHORITY: Implementing Section 11.5 of the Salem Civic Center Use and Occupation Tax Law of the Salem Civic Center Law (70 ILCS 835/11.5) and authorized by Section 39b29 of the Civil Administrative Code of Illinois (20 ILCS 2505/39b29).

SOURCE: Adopted at 20 Ill. Reg. _____, effective _____.

Section 690.101 Nature of the Salem Civic Center Retailers' Occupation Tax

a) Authority to Impose Tax
The Authority is authorized by Section 11.5 of the Salem Civic Center Law (70 ILCS 835/11.5) (the Law) to impose a tax, the Salem Civic Center Retailers' Occupation Tax, on all persons engaged in the business of selling tangible personal property at retail in the metropolitan area on the gross receipts from sales made in the course of such business within the metropolitan area, if a proposition for the tax has been submitted to the electors of that metropolitan area and approved by a majority of those voting on the question. If imposed, such tax shall only be imposed in 1/4% increments at a rate not to exceed 1%. The tax imposed by the Authority under the Law and this Part, and all civil penalties that may be assessed as an incident thereof, shall be collected and enforced by the Illinois Department of Revenue (Department).

b) Passing on the Tax
The legal incidence of the Salem Civic Center Retailers' Occupation Tax is on the seller. Nevertheless, the General Assembly has authorized persons subject to any tax imposed pursuant to the authority granted in the Salem Civic Center Use and Occupation Tax Law to reimburse themselves for their Salem Civic Center Retailers' Occupation Tax liability by separately stating such tax as an additional charge, which charge may be stated in combination, in a

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single amount, with State tax which sellers are required to collect under the Use Tax Act (35 ILCS 105), pursuant to such bracket schedules as the Department has prescribed (see 86 Ill. Adm. Code 150.Zeble A).

c) Exclusion from "Gross Receipts"
Any amount added to the selling price of tangible personal property by the seller because of a Salem Civic Center Retailers' Occupation Tax, or because of the Illinois Retailers' Occupation Tax (35 ILCS 120), the Illinois Use Tax (35 ILCS 105), the Home Rule Municipal Retailers' Occupation Tax (65 ILCS 5 8-11-1), the Non-Home Rule Municipal Retailers' Occupation Tax (65 ILCS 5 8-11-1.3), the Metro East Mass Transit District Retailers' Occupation Tax (70 ILCS 3610.5.11), the Regional Transportation Authority Retailers' Occupation Tax (70 ILCS 3615.4.23) or the County Water Commission Retailers' Occupation Tax (70 ILCS 3720.4.01), and collected from the purchaser, shall not be regarded as a part of the seller's gross receipts that are subject to such Salem Civic Center Retailers' Occupation Tax.

Section 630.105 Registration and Returns

a) Separate Registration not Required
A retailer's registration under the Illinois Retailers' Occupation Tax Act (35 ILCS 120) is sufficient for the Salem Civic Center Use and Occupation Tax Law. No special registration for the Salem Civic Center Retailers' Occupation Tax is required.

b) Requirements as to Returns
1) The information required for the Salem Civic Center Retailers' Occupation Tax shall be furnished on the retailer's Retailers' Occupation Tax return form.
2) If the retailer files his Illinois Retailers' Occupation Tax returns on the gross receipts basis, he must report Salem Civic Center Retailers' Occupation Tax information in his returns on the same basis. If the retailer files his Illinois Retailers' Occupation Tax returns on the gross sales basis, he must report Salem Civic Center Retailers' Occupation Tax information in his returns on the gross sales basis.

Section 630.110 Claims to Recover Erroneously Paid Tax

Claims for Multiple Taxes. If a claimant files a claim for refund on a transaction which was subject to State and local taxes administered by the Department, the claim need not be filed separately for each type of tax. A single claim for the total of all applicable taxes will suffice. The claim will be audited, heard, or otherwise processed as a single claim whenever possible. A single credit memorandum will be issued which may be used by the claimant or his authorized assignee to pay State or local tax liability.

Section 630.115 Jurisdictional Questions

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a) Metropolitan Area Defined
When used in this Part, "metropolitan area" means all territory in the State of Illinois lying within the corporate boundaries of the City of Salem in Marion County.

b) Mere Solicitation of Orders not Doing Business
1) For a seller to incur Salem Civic Center Retailers' Occupation Tax liability in a given metropolitan area, the sale must be made in the course of such seller's engaging in the retail business within such metropolitan area. In other words, enough of the selling activity must occur within the metropolitan area to justify concluding that the seller is engaged in business within the metropolitan area with respect to that sale.
2) For example, the Supreme Court has held the mere solicitation and receipt of orders within a taxing jurisdiction (the State), where such orders were subject to acceptance outside the taxing jurisdiction and title passed outside such jurisdiction, with the goods being shipped from outside such jurisdiction to the purchaser in such jurisdiction, did not constitute engaging in the business of selling within such jurisdiction. This conclusion was reached independently of any question of interstate commerce and so would apply to the metropolitan area as the taxing jurisdiction as much as to the State as the taxing jurisdiction.

c) Seller's Acceptance of Order
1) Without attempting to anticipate every kind of fact situation that may arise in this connection, it is the Department's opinion, in general, that the seller's acceptance of the purchase order or other contracting action in the making of the sales contract is the most important single factor in the occupation of selling. If the purchase order is accepted at the seller's place of business within the county or by someone who is working out of such place of business and who does not conduct the business of selling elsewhere within the meaning of subsections (g) and (h) of this Section, or if a purchase order which is an acceptance if the seller's complete and unconditional offer to sell is received by the seller's place of business within the county or by someone working out of such place of business, the seller incurs Salem Civic Center Retailers' Occupation Tax liability in that metropolitan area if the sale is at retail and the purchaser receives the physical possession of the property in Illinois. The Department will assume that the seller has accepted the purchase order at the place of business at which the seller receives such purchase order from the purchaser in the absence of clear proof to the contrary.
2) If a purchase order is accepted outside this State, but the tangible personal property which is sold is in an inventory of the retailer located within the metropolitan area at the time of its sale (or is subsequently produced in Illinois), then delivered in Illinois to the purchaser, the place where the

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property is located at the time of the sale (or subsequent production in Illinois) will determine where the seller is engaged in business for Salem Civic Center Retailers' Occupation Tax purposes with respect to such sale.

d) Some Considerations that are not Controlling

1) Delivery of the property within the metropolitan area to the purchaser is not necessary for the seller to incur Salem Civic Center Retailers' Occupation Tax liability. It is sufficient that the purchaser receives the physical possession of the property somewhere in Illinois as far as the question of delivery is concerned. This is true because there is no exemption for intermetropolitan area commerce comparable to the exemption arising from interstate commerce, and it is not necessary for delivery to be completed within the metropolitan area for the seller to be regarded as being engaged in the business of selling within such metropolitan area with respect to that sale.

2) The point at which the tangible personal property will be used or consumed and the place at which the purchaser resides are also immaterial in determining whether or not the seller incurs Salem Civic Center Retailers' Occupation Tax liability. Furthermore, the place at which the technical sale occurs (i.e., the place at which title passes) is not a decisive consideration since the phrase "in the metropolitan area" in the Salem Civic Center Use and Occupation Tax Law refers only to the location of the occupation of selling that is being taxed and not to the place where sales may be made. (See Standard Oil Company vs. Department of Finance et al., 383 Ill. 136 (1934), for a similar problem under the Illinois Retailers' Occupation Tax Act.)

e) Place of Business Where Long Term or Blanket Contracts are Involved
Under a long term blanket or master contract which (though definite as to price and quantity) must be implemented by the purchaser's placing of specific orders when goods are wanted, the seller's place of business with which such subsequent specific orders are placed (rather than the place where the seller signed the master contract) will determine where the seller is engaged in business for Salem Civic Center Retailers' Occupation Tax purposes with respect to such orders.

f) Sales Through Vending Machines
The seller's place of engaging in business when making sales through a vending machine is the place where the vending machine is located when such sales are made.

g) Sales from Vehicles Carrying Uncommitted Stock of Goods
The seller's place of engaging in business when making sales and deliveries (not just deliveries pursuant to previously accepted orders, but actual sales and deliveries) from a vehicle in which a stock of goods is being carried for sale is the place at which such sales and deliveries happen to be made - the vehicle carrying such stock of goods for sale being regarded as a portable place of business.

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h) Sales of Coal or Other Minerals
For the purpose of determining the tax that is applicable, a retail sale, by a producer of coal or other mineral mined in Illinois, is a sale at retail at the place where the coal or other mineral mined in Illinois is extracted from the earth.

1) A retail sale is a sale to a user, such as a railroad, public utility or other industrial company, for use. "Mineral" includes not only coal, but also oil, sand, stone taken from a quarry, gravel and any other thing commonly regarded as a mineral and extracted from the earth.

2) A mineral produced in Illinois, but shipped out of Illinois by the seller for use outside Illinois, will generally be tax exempt under the Commerce Clause of the Federal Constitution (i.e., as a sale in interstate commerce). This exemption does not extend, however, to sales to carriers, other than common carriers by rail, for their own use outside Illinois if the purchasing carrier takes delivery of the property in Illinois and transports it over its own line to an out-of-State destination.

3) A sale by a mineral producer to a wholesaler or retailer for resale would not be a retail sale by the producer and so would not be taxable. The taxable sale (the retail sale) is the final sale to the user, and the Salem Civic Center Retailers' Occupation Tax for that sale will go to the metropolitan area where the retailer is located.

Section 690.120 Incorporation of Retailers' Occupation Tax Regulations by Reference

To avoid needless repetition, the substance and provisions of all Retailers' Occupation Tax Regulations (86 Ill. Adm. Code 130) which are not incompatible with the Salem Civic Center Use and Occupation Tax Law or any special regulations that may be promulgated by the Department thereunder shall apply to the tax imposed pursuant to this Part.

Section 690.125 Penalties, Interest and Procedures

All penalties (both civil and criminal), provisions concerning interest and procedures (such as the making of assessments, the venue and mode of conducting hearings, suppoenas, matters pertaining to judicial review and other procedural subjects), together with statutes of limitation, are the same under the Salem Civic Center Use and Occupation Tax Law as under the Illinois Retailers' Occupation Tax Act (35 ILCS 120).

Section 690.130 Effective Date

An ordinance or resolution imposing or discontinuing or effecting a change in the rate of a Salem Civic Center Retailers' Occupation Tax shall be adopted and a certified copy thereof filed with the Department on or before the first day

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of April, whereupon the Department shall proceed to administer and enforce the ordinance or resolution as of the first day of July next following such adoption and filing. For purposes of determining which tax rate applies, the date of the sale is deemed to be the date of the delivery of the property.

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NOTICE OF PROPOSED RULEMAKING

1) Heading of the Part: Salem Civic Center Service Occupation Tax

2) Code Citation: 86 Ill. Adm. Code 691

3)

Section Numbers:	Proposed Action:
691.101	New Section
691.105	New Section
691.110	New Section
691.115	New Section
691.120	New Section
691.125	New Section
691.130	New Section

4) Statutory Authority: 20 ILCS 2505/39b.9

5) A Complete Description of the Subjects and Issues Involved: This rulemaking implements Public Act 89-460, which authorizes the Salem Civic Center Authority to impose a Service Occupation Tax in the City of Salem if approved by voters at referendum, imposed in one-quarter percent increments at a rate not to exceed 1%. Contains provisions concerning the nature of the tax, returns, etc.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a state mandate, nor does it modify any existing state mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Gina Roccaforte
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794
(217) 782-6996

12) Initial Regulatory Flexibility Analysis:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Service persons in the City of Salem, Marion County.

B) Reporting, bookkeeping or other procedures required for compliance: Minimal

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: This rule was not included in either of the 2 most recent agendas because: It was unanticipated at the time of the regulatory agenda.

The full text of the Proposed Amendment(s) begins on the next page:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 691
SALEM CIVIC CENTER SERVICE OCCUPATION TAX

Section
691.101 Nature of the Salem Civic Center Service Occupation Tax
691.105 Registration and Returns
691.110 Claims to Recover Erroneously Paid Tax
691.115 Jurisdictional Questions
691.120 Incorporation of Service Occupation Tax Regulations by Reference
691.125 Penalties, Interest and Procedures
691.130 Effective Date

AUTHORITY: Implementing Section 11.5 of the Salem Civic Center Use and Occupation Tax Law of the Salem Civic Center Law [70 ILCS 335/11.5] and authorized by Section 39b29 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b29].

SOURCE: Adopted at 20 Ill. Reg. _____, effective _____.

Section 691.101 Nature of the Salem Civic Center Service Occupation Tax

a) Authority to Impose Tax
The Authority is authorized by Section 11.5 of the Salem Civic Center Law [70 ILCS 335/11.5] (the Law) to impose a tax, the Salem Civic Center Service Occupation Tax, on all persons engaged, in the metropolitan area, in the business of making sales of service at the same rate of tax imposed pursuant to Section 11.5(b) of the Law of the selling price of all tangible personal property transferred by such serviceman either in the form of tangible personal property or in the form of real estate as an incident to such sale of service. If imposed, such tax shall only be imposed in 1/4% increments at a rate not to exceed 1%. The tax imposed by the Authority under the Law and this Part, and all civil penalties that may be assessed as an incident thereof, shall be collected and enforced by the Illinois Department of Revenue (Department).

b) Passing on the Tax
Servicemen are required to collect the Salem Civic Center Service Occupation Tax (when applicable) from purchasers of service in conformance with the requirements of the Service Occupation Tax Regulations (86 Ill. Adm. Code 140). The legal incidence of the Salem Civic Center Service Occupation Tax is on the serviceman. Nevertheless, the General Assembly has authorized persons subject to any tax imposed pursuant to the authority granted in the Salem Civic Center Use and Occupation Tax Law to reimburse themselves for their

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Salem Civic Center Service Occupation Tax liability by separately stating such tax as an additional charge, which charge may be stated in combination, in a single amount, with State tax which servicemen are authorized to collect under the Service Use Tax Act [35 ILCS 110], pursuant to such bracket schedules as the Department has prescribed (see 86 Ill. Adm. Code 150.Table A).

c) Exclusion from "Cost Price"
Any amount added by a serviceman to the selling price of tangible personal property as an incident to service because of a Salem Civic Center Service Occupation Tax, or because of the Illinois Service Occupation Tax [35 ILCS 115], the Home Rule Municipal Service Occupation Tax [65 ILCS 5/8-11-5], the Non-Home Rule Municipal Service Occupation Tax [65 ILCS 5/8-11-1.4], the Metro East Mass Transit District Service Occupation Tax [70 ILCS 3610/5.01], the Regional Transportation Authority Service Occupation Tax [70 ILCS 3615/4.03] or the County Water Commission Service Occupation Tax [70 ILCS 3720/4(c)], shall not be regarded as a part of the selling price which is subject to such Salem Civic Center Service Occupation Tax.

Section 691.105 Registration and Returns

a) A serviceman's registration under the Service Occupation Tax Act [35 ILCS 115] or the Illinois Retailers' Occupation Tax Act [35 ILCS 120] is sufficient for the purposes of the Salem Civic Center Use and Occupation Tax Law. No special registration for the Salem Civic Center Service Occupation Tax is required.

b) The information required for the Salem Civic Center Service Occupation Tax shall be furnished on the taxpayer's Illinois Service Occupation Tax return form.

c) The provisions of the Service Occupation Tax Regulations (86 Ill. Adm. Code 140) shall apply to the tax imposed pursuant to this Part.

Section 691.110 Claims to Recover Erroneously Paid Tax

Claims for Multiple Taxes. If a claimant files a claim for refund on a transaction which was subject to State and local taxes administered by the Department, the claim need not be filed separately for each type of tax. A single claim for the total of all applicable taxes will suffice. The claim will be audited, heard, or otherwise processed as a single claim whenever possible. A single credit memorandum will be issued which may be used by the claimant or his authorized assignee to pay State or local tax liability.

Section 691.115 Jurisdictional Questions

a) When used in this Part, "metropolitan area" means all territory in the State of Illinois lying within the corporate boundaries of the City of Salem in Marion County.

b) If the Illinois Service Occupation Tax on a transaction is being

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remitted to the Department by the serviceman, the serviceman shall also pay Salem Civic Center Service Occupation Tax to the Department on the same transaction if such serviceman's place of business is located in the metropolitan area.

Section 691.120 Incorporation of Service Occupation Tax Regulations by Reference

To avoid needless repetition, the substance and provisions of all Service Occupation Tax Regulations (86 Ill. Adm. Code 140) which are not incompatible with the Salem Civic Center Use and Occupation Tax Law or any special regulations that may be promulgated by the Department thereunder shall apply to the tax imposed pursuant to this Part.

Section 691.125 Penalties, Interest and Procedures

All penalties (both civil and criminal), provisions concerning interest and procedures (such as the making of assessments, the venue and mode of conducting hearings, subpoenas, matters pertaining to judicial review and other procedural subjects), together with statutes of limitation, are the same under the Salem Civic Center Use and Occupation Tax Law as under the Service Occupation Tax Act.

Section 691.130 Effective Date

An ordinance or resolution imposing or discontinuing or effecting a change in the rate of a Salem Civic Center Service Occupation Tax shall be adopted and a certified copy thereof filed with the Department on or before the first day of April, whereupon the Department shall proceed to administer and enforce the ordinance or resolution as of the first day of July next following such adoption and filing. For purposes of determining which tax rate applies, the date of the sale of service is deemed to be the date of the delivery, to the user, of the tangible personal property which the serviceman retransfers as an incident to service.

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

1) Heading of the Part: Salem Civic Center Use Tax

2) Code Citation: 86 Ill. Adm. Code 692

3)

Section Numbers:	Proposed Action:
692.101	New Section
692.105	New Section
692.110	New Section
692.115	New Section
692.120	New Section

4) Statutory Authority: 20 ILCS 2505/39b19

5) A Complete Description of the Subjects and Issues Involved: This rulemaking implements Public Act 89-460, which authorizes the Salem Civic Center Authority to impose a Use Tax in the City of Salem if approved by voters at referendum, imposed in one-quarter percent increments at a rate not to exceed 1%. Contains provisions concerning the nature of the tax, returns, etc.

6) Will this proposed rule replace an emergency rule currently in effect?: No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a state mandate, nor does it modify any existing state mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Gina Roccaforte
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794
(217) 782-6996

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit

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NOTICE OF PROPOSED RULEMAKING

corporations affected: Users of tangible personal property in the City of Salem, Marion County.

B) Reporting, bookkeeping or other procedures required for compliance: Minimal

C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: This rule was not included in either of the 2 most recent agendas because: It was unanticipated at the time of the regulatory agenda.

The full text of the Proposed Amendment(s) begins on the next page:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED RULEMAKING

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 692
SALEM CIVIC CENTER USE TAX

Section
692.101 Nature of the Salem Civic Center Use Tax
692.105 Items Covered
692.110 Incorporation of Use Tax Regulations by Reference
692.115 Penalties, Interest and Procedures
692.120 Effective Date

AUTHORITY: Implementing Section 11.5 of the Salem Civic Center Use and Occupation Tax Law of the Salem Civic Center Law [70 ILCS 335/11.5] and authorized by Section 39b29 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b29].

SOURCE: Adopted at 20 Ill. Reg. _____, effective _____.

Section 692.101 Nature of the Salem Civic Center Use Tax

The Authority is authorized by Section 11.5 of the Salem Civic Center Law [70 ILCS 335/11.5] (the Law) to impose a tax, the Salem Civic Center Use Tax, upon the privilege of using, in the metropolitan area, any item of tangible personal property that is purchased outside the metropolitan area at retail from a retailer, and that is titled or registered at a location within the metropolitan area with an agency of this State's government, at the same rate of tax imposed pursuant to Section 11.5(b) of the Law of the selling price of such tangible personal property, as selling price is defined in the Use Tax Act. If imposed, such tax shall only be imposed in 1/4% increments at a rate not to exceed 1%. The tax imposed by the Authority under the Law and this Part, and all civil penalties that may be assessed as an incident thereof, shall be collected and enforced by the Illinois Department of Revenue (Department).

Section 692.105 Items Covered

Items that are titled or registered with the State are motor vehicles, aircraft, watercraft, snowmobiles, and implements of husbandry and special mobile equipment for which the owner decides to apply for an optional title. For the purposes of this Part:

a) The term "motor vehicle" includes passenger cars, trucks, buses, motorcycles and any kind of vehicle that is required to be titled under the Illinois Vehicle Code [625 ILCS 5], including house trailers for which a display certificate of title is required.

b) The term "implement of husbandry" means *every vehicle designed and adapted exclusively for agricultural, horticultural or livestock raising operations, including farm wagons, wagon trailers or like vehicles used in connection therewith, or for lifting or carrying an implement of husbandry provided that no farm wagon, wagon trailer or like vehicle having a gross weight of more than 36,000 pounds shall be included hereunder.* [625 ILCS 5/1-130]

c) The term "special mobile equipment" means *every vehicle not designed or used primarily for the transportation of persons or property and only incidentally operated or moved over a highway, including but not limited to: street sweepers, ditch digging apparatus, well boring apparatus and road construction and maintenance machinery such as asphalt spreaders, bituminous mixers, bucket graders, finishing machines, motor graders, road rollers, scarifiers, earth moving carryalls and scrapers, power shovels and drag lines, and self-propelled cranes and earth moving equipment. The term does not include house trailers, dump trucks, truck mounted transit mixers, cranes or shovels, or other vehicles designed for the transportation of persons or property to which machinery has been attached.* [625 ILCS 5/1-149]

d) *Watercraft means every description of watercraft used or capable of being used as a means of transportation on water, except a seaplane on the water, innertube, air mattress or similar device, and boats used for concession rides in artificial bodies of water designed and used exclusively for such concessions.* (Section 1-2 of the Boat Registration and Safety Act [625 ILCS 45/1-2] *Every watercraft other than sailboards, on waters within the jurisdiction of this State, shall be numbered.* [625 ILCS 45/3-1]

Section 692.110 Incorporation of Use Tax Regulations by Reference

To avoid needless repetition, the substance and provisions of all Use Tax Rules (86 Ill. Adm. Code 150), except Subpart A as it pertains to subject matter and rate; Subpart G as it pertains to registration of out-of-State retailers; Subpart H as it pertains to deduction for collecting tax; and Subpart M as it pertains to retailers and the use of a credit memorandum to discharge State or municipal tax liabilities, shall apply to the tax imposed pursuant to this Part.

Section 692.115 Penalties, Interest and Procedures

All penalties (both civil and criminal), provisions concerning interest and procedures (such as the making of assessments, the venue and mode of conducting hearings, subpoenas, matters pertaining to judicial review and other procedural subjects), together with statutes of limitation, are the same under the Salem Civic Center Use and Occupation Tax Law as under the Illinois Use Tax Act [35 ILCS 105].

Section 692.120 Effective Date

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An ordinance or resolution imposing or discontinuing or effecting a change in the rate of a Salem Civic Center Use Tax shall be adopted and a certified copy thereof filed with the Department on or before the first day of April, whereupon the Department shall proceed to administer and enforce the ordinance or resolution as of the first day of July next following such adoption and filing. For purposes of determining which tax rate applies, the date of the purchase is deemed to be the date of the delivery of the property.

DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Meat and Poultry Inspection Act

2) Code Citation: 8 Ill. Adm. Code 125

3)

Section Numbers:	Adopted Action:
125.80	Amendment
125.300	Amendment

4) Statutory Authority: Meat and Poultry Inspection Act [225 ILCS 650] and Section 16 of the Civil Administrative Code of Illinois [20 ILCS 5/16]

5) Effective Date of amendments: September 1, 1996

6) Does this rulemaking contain an automatic repeal date? No

7) Does this proposed amendment contain incorporations by reference? Yes

8) Date Filed in Agency's Principal Office: September 1, 1996

9) Date Notice of Proposed Amendments was Published in the Illinois Register: May 17, 1996, 20 Ill. Reg. 6626

10) Has JCAR issued a Statement of Objections to these rules? No

11) Differences between proposal and final version: None

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? N/A

13) Will this amendment replace an emergency amendment in effect? No

14) Are there any amendments pending on this Part? Yes, peremptory amendments published at 20 Ill. Reg. 10403, August 2, 1996, Sections 125.100, 125.260, 125.270, 125.380, and 125.390.

15) Summary and Purpose of amendments: In Section 125.80, the Department is increasing the overtime/holiday rate for meat and poultry inspection to help cover actual costs incurred by the Department for providing those services. Since the licensee must request that the Department provide overtime/ holiday meat and poultry inspection, any expense for overtime or holidays is at the option of the establishment. The procedure for requesting overtime/holiday inspection services is also being clarified. In Section 125.300, the charge for special services is being increased.

16) Information and questions regarding this adopted amendment shall be directed to:

Debbie Wakefield

DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENTS

Illinois Department of Agriculture
State Fairgrounds
Springfield, Illinois 62794-9281
Telephone: 217/785-5713 Fax: 217/785-4505

The full text of Adopted Amendments begins on the next page:

DEPARTMENT OF AGRICULTURE

NOTICE OF ADOPTED AMENDMENTS

TITLE 8: AGRICULTURE AND ANIMALS
CHAPTER I: DEPARTMENT OF AGRICULTURE
SUBCHAPTER c: MEAT AND POULTRY INSPECTION ACT

PART 125
MEAT AND POULTRY INSPECTION ACT

SUBPART A: GENERAL PROVISIONS FOR BOTH MEAT AND/OR POULTRY INSPECTION

SUBPART B: MEAT INSPECTION

DEPARTMENT OF AGRICULTURE

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125.305 Exotic Animal Inspection

SUBPART C: POULTRY INSPECTION

Section
125.310 Application of Inspection
125.320 Facilities for Inspection
125.330 Sanitation
125.340 Operating Procedures
125.350 Ante-Mortem Inspection
125.360 Post-Mortem Inspection; Disposition of Carcasses and Parts
125.370 Handling and Disposal of Condemned or Inedible Products at Official Establishments
125.380 Labeling and Containers
125.390 Entry of Articles Into Official Establishments; Processing Inspection and Other Reinspections; Processing Requirements
125.400 Definitions and Standards of Identity or Composition
125.410 Transportation; Sale of Poultry or Poultry Products

AUTHORITY: Implementing and authorized by the Meat and Poultry Inspection Act [225 ILCS 650] and Section 16 of the Civil Administrative Code of Illinois [20 ILCS 5/16].

SOURCE: Adopted at 9 Ill. Reg. 1782, effective January 24, 1985; peremptory amendment at 9 Ill. Reg. 2337, effective January 28, 1985; peremptory amendment at 9 Ill. Reg. 2980, effective February 20, 1985; peremptory amendment at 9 Ill. Reg. 4856, effective April 1, 1985; peremptory amendment at 9 Ill. Reg. 9240, effective June 5, 1985; peremptory amendment at 9 Ill. Reg. 10102, effective June 13, 1985; peremptory amendment at 9 Ill. Reg. 11673, effective July 17, 1985; peremptory amendment at 9 Ill. Reg. 13748, effective August 23, 1985; peremptory amendment at 9 Ill. Reg. 15575, effective October 2, 1985; peremptory amendment at 9 Ill. Reg. 19759, effective December 5, 1985; peremptory amendment at 10 Ill. Reg. 447, effective December 23, 1985; peremptory amendment at 10 Ill. Reg. 1307, effective January 7, 1986; peremptory amendment at 10 Ill. Reg. 3318, effective January 24, 1986; peremptory amendment at 10 Ill. Reg. 3880, effective February 7, 1986; peremptory amendment at 10 Ill. Reg. 11478, effective June 25, 1986; peremptory amendment at 10 Ill. Reg. 14858, effective August 22, 1986; peremptory amendment at 10 Ill. Reg. 15305, effective September 10, 1986; peremptory amendment at 10 Ill. Reg. 16743, effective September 19, 1986; peremptory amendment at 10 Ill. Reg. 18203, effective October 15, 1986; peremptory amendment at 10 Ill. Reg. 19818, effective November 12, 1986; peremptory amendment at 11 Ill. Reg. 1696, effective January 5, 1987; peremptory amendment at 11 Ill. Reg. 2930, effective January 23, 1987; peremptory amendment at 11 Ill. Reg. 9645, effective April 29, 1987; peremptory amendment at 11 Ill. Reg. 10321, effective May 15, 1987; peremptory amendment at 11 Ill. Reg. 11184, effective June 5, 1987; peremptory amendment at 11 Ill. Reg. 14830, effective August 25, 1987; peremptory amendment at 11 Ill. Reg. 18799, effective November

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3, 1987; peremptory amendment at 11 Ill. Reg. 19805, effective November 19, 1987; peremptory amendment at 12 Ill. Reg. 2154, effective January 6, 1988; amended at 12 Ill. Reg. 3417, effective January 22, 1988; peremptory amendment at 12 Ill. Reg. 4879, effective February 25, 1988; peremptory amendment at 12 Ill. Reg. 6313, effective March 21, 1988; peremptory amendment at 12 Ill. Reg. 6819, effective March 29, 1988; peremptory amendment at 12 Ill. Reg. 13621, effective August 8, 1988; peremptory amendment at 12 Ill. Reg. 19116, effective November 1, 1988; peremptory amendment at 12 Ill. Reg. 20894, effective December 21, 1988; peremptory amendment at 13 Ill. Reg. 228, effective January 11, 1989; peremptory amendment at 13 Ill. Reg. 2160, effective February 13, 1989; amended at 13 Ill. Reg. 3696, effective March 13, 1989; peremptory amendment at 13 Ill. Reg. 15853, effective October 5, 1989; peremptory amendment at 13 Ill. Reg. 16838, effective October 11, 1989; peremptory amendment at 13 Ill. Reg. 17495, effective January 18, 1990; amended at 14 Ill. Reg. 3424, effective February 26, 1990; peremptory amendment at 14 Ill. Reg. 4953, effective March 23, 1990; peremptory amendment at 14 Ill. Reg. 11401, effective July 6, 1990; peremptory amendment at 14 Ill. Reg. 13355, effective August 20, 1990; peremptory amendment at 14 Ill. Reg. 16064, effective September 24, 1990; peremptory amendment at 14 Ill. Reg. 21060, effective May 29, 1991; peremptory amendment at 15 Ill. Reg. 620, effective January 2, 1991; peremptory amendment withdrawn at 15 Ill. Reg. 1574, effective January 2, 1991; peremptory amendment at 15 Ill. Reg. 3117, effective September 3, 1991; peremptory amendment at 15 Ill. Reg. 8714, effective May 29, 1991; amended at 15 Ill. Reg. 8801, effective June 7, 1991; peremptory amendment at 15 Ill. Reg. 13976, effective September 20, 1991; peremptory amendment at 16 Ill. Reg. 1399, effective March 2, 1992; amended at 16 Ill. Reg. 8349, effective May 26, 1992; peremptory amendment at 16 Ill. Reg. 11687, effective July 10, 1992; peremptory amendment at 16 Ill. Reg. 11963, effective July 22, 1992; peremptory amendment at 16 Ill. Reg. 12234, effective July 24, 1992; peremptory amendment at 16 Ill. Reg. 16337, effective October 19, 1992; peremptory amendment at 16 Ill. Reg. 17165, effective October 31, 1992; peremptory amendment at 17 Ill. Reg. 2063, effective February 12, 1993; peremptory amendment at 17 Ill. Reg. 15725, effective September 7, 1993; peremptory amendment at 17 Ill. Reg. 16238, effective September 8, 1993; peremptory amendment at 17 Ill. Reg. 18215, effective October 5, 1993; peremptory amendment at 18 Ill. Reg. 304, effective December 23, 1993; peremptory amendment at 18 Ill. Reg. 2164, effective January 24, 1994; amended at 18 Ill. Reg. 4622, effective March 14, 1994; peremptory amendment at 18 Ill. Reg. 6442, effective April 18, 1994; peremptory amendment at 18 Ill. Reg. 8493, effective May 27, 1994; amended at 18 Ill. Reg. 11489, effective July 7, 1994; peremptory amendment at 18 Ill. Reg. 12546, effective July 29, 1994; peremptory amendment at 18 Ill. Reg. 14475, effective September 7, 1994; amended at 18 Ill. Reg. 14924, effective September 16, 1994; peremptory amendment at 18 Ill. Reg. 15452, effective September 27, 1994; peremptory amendment at 19 Ill. Reg. 1342, effective January 27, 1995; peremptory amendment at 19 Ill. Reg. 4765, effective March 13, 1995; peremptory amendment at 19 Ill. Reg. 7067, effective May 8, 1995; peremptory amendment at 19 Ill. Reg. 14896, effective October 6, 1995; peremptory amendment at 19 Ill. Reg. 15766, effective November 10, 1995; peremptory amendment at 19 Ill. Reg.

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16866, effective December 22, 1995; peremptory amendment at 20 Ill. Reg. 5091, effective March 19, 1996; amended at 20 Ill. Reg. 11928, effective ~~SEP 01 1996~~.

SUBPART A: GENERAL PROVISIONS FOR BOTH MEAT AND/OR POULTRY INSPECTION

Section 125.80 Schedule of Operations; Overtime

a) The Department incorporates by reference 9 CFR 307.4(a), 307.4(d), and 381.37(a) and (d) (1990). References to 9 CFR 307.6(b) and 381.39(b) in the incorporated language shall be interpreted according to ~~to mean as set forth in~~ this Section.

b) The basic workweek and workday shall be those days and hours as on file and approved by the Department of Central Management Services in accordance with the Personnel Code ~~(Ill. Rev. Stat. 1989, ch. 127, par. 63b23, et seq.)~~ [20 ILCS 415] and the rules for that Act (80 Ill. Adm. Code 303.300). The work schedule of the licensee ~~official establishment~~ and any requests for changes in the work schedule shall be submitted in writing by the licensee to the regional administrator supervisor. A grant of overtime shall be at the sole discretion of the Department and shall be based on inspector availability, efficiency and efficient use of resources and budget considerations. However, minor deviations (one hour or less) from the daily operating schedule shall be approved by the inspector and the regional administrator if the request is received by the regional office on the day before the change is to occur and the change is only for that particular day.

c) For inspection services rendered on a holiday or any day or workday at times other than the hours set forth in the approved work schedule, the rate shall be $25.00 per hour or any fraction of an hour. ~~Overtime charges for inspection services rendered shall be as follows:~~

~~1) For inspection on a Saturday, Sunday or on a workday at times other than the hours as set forth in the approved work schedule the rate shall be $15.00 per hour or any fraction of an hour.~~

~~2) For inspection on holidays, the rate shall be $22.00 per hour or any fraction of an hour.~~

d) The overtime charge shall be for the actual time the inspector is performing the inspection service and associated travel. Travel expenses and the minimum overtime that will be billed are as follows:

1) When an inspector has departed the official establishment after the completion of his/her regular workday and is recalled to perform inspection service, the minimum overtime that will be charged shall be two hours.

2) For inspection service rendered on Saturday, Sunday or on a holiday, the minimum overtime that will be charged is two hours.

3) When an inspector is required to return to the establishment after the completion of his/her regular work day or on a Saturday, Sunday or holiday, the official establishment will be billed for mileage charged by the inspector in accordance with Travel Regulations (80 Ill. Adm. Code 2800) in addition to the overtime charged.

(Source: Amended at 20 Ill. Reg. 11928, effective SEP 01 1996)

SUBPART B: MEAT INSPECTION

Section 125.300 Special Services Relating to Meat and Other Products

a) The Department incorporates by reference 9 CFR 350.1 through 350.3(a), 350.3(c), 350.5 through 350.7(a) and 350.7(d) (1990).

b) The charges for special services shall be paid by check, draft or money order payable to the Illinois Department of Agriculture upon furnishing to the person who requested the service a statement as to the amount due. The fee for rendering these services shall be at the rate of $25 ~~$15~~ per hour, except for services rendered on a holiday which shall be $30. The person who requested the special service shall also be billed for travel expenses incurred by the inspector in accordance with Travel Regulations (80 Ill. Adm. Code 2800).

(Source: Amended at 20 Ill. Reg. 11928, effective SEP 01 1996)

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NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Food Stamps

2) Code Citation: 89 Ill. Adm. Code 121

3) Section Numbers: Adopted Action:
121.151 Amendment
121.182 Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and General Letter No. 96-13 from USDA.

5) Effective Date of Amendments: August 14, 1996

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: August 14, 1996

9) Notice of Proposal Published in Illinois Register:

Section 121.151
April 12, 1996 (20 Ill. Reg. 5440)

Section 121.182
April 26, 1996 (20 Ill. Reg. 5986)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: The following changes were made in the text of the proposed amendments:

Section 121.151

1. In Section 121.151(a), "program" was changed to "Program" and "as set forth in Section 121.153(a)" was enclosed in commas.

2. In Section 121.151(b), a comma was added after "Program".

3. In Sections 121.151(b) and (c), "hearing" was added before "decision".

No other changes have been made in the text of the proposed amendments.
Section 121.182

No changes have been made in the text of the proposed amendments.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Amendments replace Emergency Amendments currently in effect?

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No

14) Are there any Amendments pending on this Part? Yes

Sections	Proposed Action	Illinois Register Citation
121.22	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.23	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.24	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.25	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.26	New Section	August 2, 1996 (20 Ill. Reg. 10263)
121.27	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.29	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.30	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.31	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.63	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.71	Amendment	August 2, 1996 (20 Ill. Reg. 10263)
121.75	Amendment	August 2, 1996 (20 Ill. Reg. 10263)

15) Summary and Purpose of Amendments:

Section 121.151

When a decision has been made that a person committed an Intentional Program Violation (IPV), the individual is disqualified from receiving food stamp benefits for a set period of time. Pursuant to a directive from the USDA Food and Consumer Service, this rulemaking changes when the period of disqualification will be implemented. In the Garcia Decision, the 9th Circuit Federal Court found that the current federal regulations still apply as to the determination of a disqualification period for an intentional program violation. The court ruled, however, that disqualifications shall no longer be pended but must be imposed immediately, even if the client is no longer receiving food stamp benefits.

As a result of these adopted amendments, the disqualification period will start immediately whether or not the person is currently receiving food stamp benefits. For persons participating in the Food Stamp Program, the disqualification period will begin no later than the second fiscal month after the month of the IPV decision. For persons not participating in the Food Stamp Program, the disqualification period will begin the month after the month of the IPV decision.

Section 121.182

These amendments enable the Department to establish and maintain 26 hours as the standard maximum food stamp workoff for Earnfare participants. The hours of Earnfare work obligation for food stamp benefits equal the amount

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of food stamp benefits divided by the federal minimum wage up to a maximum of 26 hours. Any additional hours of work obligation due to food stamp allotment increases will be deemed to be met by "Earnfare Activities" such as orientations, assessments and reassessments. This rulemaking will maintain the number of hours worked per month at 80 and earnings at $231.

According to Department rule at Section 121.182(h), Earnfare participants prior to earning wages "shall engage in work equal to the amount of the food stamp benefits divided by the federal minimum wage". Subsequently, the Earnfare participant receives payment for each additional hour of performance in Earnfare activity up to a maximum of $231.00 per month. In October 1994, the Food and Nutrition Service (FNS) increased the maximum monthly food stamp allotment for a single individual from $112 to $115, thereby suggesting an increase in the number of food stamp workoff hours to 27. At that time, the Department decided to maintain the food stamp workoff hours at 26 counting the additional hour toward "Earnfare activity". Participant earnings remained at $231 per month and maximum hours worked at 80.

In December 1995, FNS increased the maximum monthly food stamp allotment for a single individual from $115 to $119. This change would indicate an increase in the food stamp workoff hours to 28 hours. It would require the participant to work 28 hours (food stamp allotment) before earning any money. This increase could have an adverse impact on client participation.

In the best interest of the client and the Earnfare program, these adopted amendments allow for the food stamp workoff hours to remain the same. This rulemaking creates greater program flexibility, by increasing the amount of time a client can participate in Earnfare-related activities, such as orientations, assessments and reassessments. This increased flexibility will enhance the caseworker's ability to assess a client, match a client with an employer and make any necessary referrals. It will also provide a greater incentive for clients to participate in the Earnfare program.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Judy Umunna
Address: Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, Illinois 62762
Telephone: (217) 524-0081

The full text of the Adopted Amendments begins on the next page:

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NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 121
FOOD STAMPS

SUBPART A: APPLICATION PROCEDURES

Section
121.1 Application for Assistance
121.2 Time Limitations on the Disposition of an Application
121.3 Approval of an Application and Initial Authorization of Assistance
121.4 Denial of an Application
121.5 Client Cooperation
121.6 Emergency Assistance
121.7 Expedited Services
121.10 Interviews

SUBPART B: NON-FINANCIAL FACTORS OF ELIGIBILITY

Section
121.19 Ending a Voluntary Quit Disqualification
121.20 Citizenship
121.21 Residence
121.22 Social Security Numbers
121.23 Work Registration/Participation Requirements (Repealed)
121.24 Individuals Exempt From Work Registration Requirements (Repealed)
121.25 Failure to Comply (Repealed)
121.26 Period of Disqualification (Repealed)
121.27 Voluntary Job Quit
121.28 Good Cause for Voluntary Job Quit
121.29 Exemptions from Voluntary Quit Rule

SUBPART C: FINANCIAL FACTORS OF ELIGIBILITY

Section
121.30 Unearned Income
121.31 Exempt Unearned Income
121.32 Education Benefits
121.33 Unearned Income In-Kind
121.34 Lump Sum Payments and Income Tax Refunds
121.40 Earned Income
121.41 Budgeting Earned Income
121.50 Exempt Earned Income
121.51 Income from Work Study/Training Programs
121.52 Earned Income from Roomer and Boarder

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SUBPART D: ELIGIBILITY STANDARDS

SUBPART E: HOUSEHOLD CONCEPT

SUBPART F: MISCELLANEOUS PROGRAM PROVISIONS

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SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

AUTHORITY: Implementing Sections 12-4.4 through 12-4.6 and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-4.4 through 12-4.6 and 12-13].

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SOURCE: Adopted December 30, 1977; amended at 3 Ill. Reg. 5, p. 875, effective February 2, 1979; amended at 3 Ill. Reg. 31, p. 109, effective August 3, 1979; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 41, p. 165, effective October 11, 1979; amended at 3 Ill. Reg. 42, p. 230, effective October 9, 1979; amended at 3 Ill. Reg. 44, p. 173, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 3, p. 49, effective January 9, 1980; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 23, 1980; amended at 4 Ill. Reg. 10, p. 253, effective February 27, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 20, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 17, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1131, effective January 16, 1981; amended at 5 Ill. Reg. 4586, effective April 15, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 12736, effective October 29, 1981; amended at 6 Ill. Reg. 1653, effective January 17, 1982; amended at 6 Ill. Reg. 2707, effective March 2, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 12208, effective August 9, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 194, effective January 1, 1983; codified at 7 Ill. Reg. 5195; amended at 7 Ill. Reg. 5715, effective May 1, 1983; amended at 7 Ill. Reg. 8118, effective June 24, 1983; peremptory amendment at 7 Ill. Reg. 12899, effective October 1, 1983; amended at 7 Ill. Reg. 13655, effective October 4, 1983; peremptory amendment at 7 Ill. Reg. 16067, effective November 15, 1983; amended at 7 Ill. Reg. 16169, effective November 22, 1983; amended at 8 Ill. Reg. 5673, effective April 18, 1984; amended at 8 Ill. Reg. 7249, effective May 16, 1984; peremptory amendment at 8 Ill. Reg. 10086, effective July 1, 1984; amended at 8 Ill. Reg. 13284, effective July 16, 1984; amended at 8 Ill. Reg. 17900, effective September 14, 1984; amended (by adding Section being codified with no substantive change) at 8 Ill. Reg. 17898; peremptory amendment at 8 Ill. Reg. 19690, effective October 1, 1984; peremptory amendment at 8 Ill. Reg. 22145, effective November 1, 1984; amended at 9 Ill. Reg. 302, effective January 1, 1985; amended at 9 Ill. Reg. 1304, effective May 1, 1985; amended at 9 Ill. Reg. 8665, effective May 29, 1985; peremptory amendment at 9 Ill. Reg. 8898, effective July 1, 1985; amended at 9 Ill. Reg. 11334, effective July 9, 1985; amended at 9 Ill. Reg. 14334, effective September 6, 1985; peremptory amendment at 9 Ill. Reg. 15582, effective October 1, 1985; amended at 9 Ill. Reg. 16889, effective October 16, 1985; amended at 9 Ill. Reg. 19726, effective December 9, 1985; amended at 10 Ill. Reg. 229, effective December 20, 1985; peremptory amendment at 10 Ill. Reg. 7387, effective April 21, 1986; peremptory amendment at 10 Ill. Reg. 7941, effective May 1, 1986; amended at 10 Ill. Reg. 14692, effective August 29, 1986; peremptory amendment at 10 Ill. Reg. 15714, effective October 1, 1986; Sections 121.200 thru 121.208 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; peremptory amendment at 11 Ill. Reg. 3761, effective February 11, 1987; emergency amendment at 11 Ill. Reg. 3754, effective February 13, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 9968, effective May 15, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 10269, effective May 22, 1987; amended at 11 Ill. Reg. 10621, effective May 25, 1987; peremptory amendment at 11 Ill. Reg. 11391, effective July 1, 1987; peremptory amendment at 11 Ill. Reg. 11855, effective June 30, 1987; emergency amendment at 11 Ill. Reg. 12043, effective July 6, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 13635, effective August 1, 1987; amended at 11 Ill. Reg. 14022, effective August 10, 1987; emergency amendment at 11 Ill. Reg. 15261, effective September 1, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 15480, effective September 4, 1987; amended at 11 Ill. Reg. 15634, effective September 11, 1987; amended at 11 Ill. Reg. 18218, effective October 30, 1987; peremptory amendment at 11 Ill. Reg. 18374, effective October 30, 1987; amended at 12 Ill. Reg. 877, effective December 30, 1987; emergency amendment at 12 Ill. Reg. 1941, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 4204, effective February 5, 1988; amended at 12 Ill. Reg. 9678, effective May 23, 1988; amended at 12 Ill. Reg. 9922, effective June 1, 1988; amended at 12 Ill. Reg. 11463, effective June 30, 1988; amended at 12 Ill. Reg. 12824, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 14045, effective August 19, 1988, for a maximum of 150 days; peremptory amendment at 12 Ill. Reg. 15704, effective October 1, 1988; peremptory amendment at 12 Ill. Reg. 16271, effective October 1, 1988; amended at 12 Ill. Reg. 16161, effective November 30, 1988; amended at 13 Ill. Reg. 3890, effective March 10, 1989; amended at 13 Ill. Reg. 12619, effective August 14, 1989; peremptory amendment at 13 Ill. Reg. 15859, effective October 1, 1989; amended at 14 Ill. Reg. 729, effective January 1, 1990; amended at 14 Ill. Reg. 6349, effective April 13, 1990; amended at 14 Ill. Reg. 13202, effective August 6, 1990; peremptory amendment at 14 Ill. Reg. 15158, effective October 1, 1990; amended at 14 Ill. Reg. 15983, effective September 30, 1990; amended at 15 Ill. Reg. 11150, effective July 22, 1991; amended at 15 Ill. Reg. 11957, effective August 12, 1991; peremptory amendment at 15 Ill. Reg. 14134, effective October 1, 1991; emergency amendment at 16 Ill. Reg. 757, effective January 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 10011, effective June 15, 1992; amended at 16 Ill. Reg. 13900, effective August 31, 1992; emergency amendment at 16 Ill. Reg. 16221, effective October 1, 1992, for a maximum of 150 days; peremptory amendment at 16 Ill. Reg. 16348, effective October 1, 1992; amended at 16 Ill. Reg. 16624, effective October 23, 1992; amended at 17 Ill. Reg. 644, effective December 31, 1992; amended at 17 Ill. Reg. 4333, effective March 19, 1993; amended at 17 Ill. Reg. 14625, effective August 26, 1993; emergency amendment at 17 Ill. Reg. 15149, effective September 7, 1993, for a maximum 150 days; peremptory amendment at 17 Ill. Reg. 17477, effective October 1, 1993; expedited correction at 17 Ill. Reg. 21216, effective October 1, 1993; amended at 18 Ill. Reg. 2033, effective January 21, 1994; emergency amendment at 18 Ill. Reg. 2509, effective January 27, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 3427, effective February 28, 1994; amended at 18 Ill. Reg. 8921, effective June 3, 1994;

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amended at 18 Ill. Reg. 12829, effective August 5, 1994; amended at 18 Ill. Reg. 14103, effective August 26, 1994; amended at 19 Ill. Reg. 5626, effective March 31, 1995; amended at 19 Ill. Reg. 9648, effective May 5, 1995; emergency amendment at 19 Ill. Reg. 12705, effective September 1, 1995, for a maximum of 150 days; peremptory amendment at 19 Ill. Reg. 13595, effective October 1, 1995; amended at 20 Ill. Reg. 1593, effective January 11, 1996; peremptory amendment at 20 Ill. Reg. 3229, effective January 17, 1996; amended at 20 Ill. Reg. 7902, effective June 1, 1996; amended at 20 Ill. Reg. 11935, effective AUG 14 1996.

SUBPART G: INTENTIONAL VIOLATIONS OF THE PROGRAM

Section 121.151 Penalties for Intentional Violations of the Program

a) Persons found to have intentionally violated the Food Stamp Program, program as set forth in Section 121.153(a), are disqualified for:
   1) 6 months for the first violation;
   2) 12 months for the second violation; and
   3) permanently for the third violation; or
   4) as As specified by a court decision.

b) If the person is currently participating in the Food Stamp Program, disqualification begins no later than the second fiscal month defined at 89 Ill. Adm. Code 101.20) after the month of the hearing decision. Once the period of disqualification is imposed, it continues regardless of the eligibility of the disqualified member's household. ~~If the individual is currently participating in the Food Stamp program disqualification begins the first fiscal month (defined at 89 Ill. Adm. Code 101.20) following the date of the notice of the hearing decision. Once the period of disqualification is imposed, it continues regardless of the eligibility of the disqualified member's household.~~

c) If the person is not participating in the Food Stamp Program, the disqualification begins the month after the month of the hearing decision. ~~If the individual is not participating at the time of the hearing decision, the disqualification is postponed until the individual is again determined eligible to receive Food Stamps.~~

d) If the individual intentionally failed to report income, the earned income deduction is not applied to that portion of income the individual failed to report (not the entire amount of earned income) when calculating the overpayment amount.

(Source: Amended at 20 Ill. Reg. 11935, effective AUG 14 1996)

SUBPART H: FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM

Section 121.182 Earnfare Component

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a) Assignment to the Earnfare Component is limited to adults who receive food stamps and who volunteer or are court-ordered to participate.

b) Eligibility Criteria
   1) Eligibility for the Earnfare Component shall be limited to six months out of any 12 consecutive month period except that court-ordered participants shall participate for less than six months out of any 12 consecutive month period.
   2) Individuals are not entitled to be placed in an Earnfare slot. Earnfare slots shall be made available only as resources permit.
   3) To the extent resources permit, the Earnfare program will allow individuals to work for monthly payments and to improve their employability in order to succeed in obtaining employment.

c) Administration and Contracts
   1) The Illinois Department shall administer the Earnfare program in Chicago.
   2) The Illinois Department may enter into cooperative agreements with local governmental units in selected geographic areas which want to participate in the operation of the Earnfare program outside the City of Chicago. The Department shall establish the policies and procedures for the program and monitor Earnfare programs in local governmental units. Local governmental units will be eligible to participate in the operation of an Earnfare program in the following priority order as resources permit:
      A) Local governmental units that receive State funds.
      B) Local governmental units that neither receive State funds nor are under a current contract with the Department will be eligible to contract with the Department to administer Earnfare. The Department will reimburse client payments, transportation and up to 50% of allowable administrative staff costs. The Department will select non-receiving units to participate in the program from the applications received based on, but not limited to, the unemployment rate, percentage of the population receiving food stamps, outreach and recruitment plans, linkage with employers and connection to a court of competent jurisdiction to enable operation of the Non-custodial Parent/Earnfare Initiative.
   3) The Illinois Department may enter into contracts with other public agencies including State agencies, local governmental units, and not-for-profit community based organizations to help develop Earnfare opportunities and otherwise administer the program.
   4) The Illinois Department may enter into contracts with community based organizations as comprehensive providers to administer and operate Earnfare in the City of Chicago.
   5) The Illinois Department shall provide Worker's Compensation coverage for each individual assigned to Earnfare.

d) Notification and Referrals
   1) In areas where an Earnfare program is operating, when the

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Illinois Department or the local governmental unit learns that individuals are in the following categories, it shall inform them in writing and, whenever possible, orally of the existence of Earnfare and the method for requesting an Earnfare referral.

A) Households approved or certified for non-assistance food stamps which do not have net food stamp income in excess of $154.00 per month;

B) All persons denied or terminated from State Transitional Assistance because they are employable; and

C) All Earnfare participants shall be given a written notice at the time they leave the Earnfare program specifying when they will re-qualify.

2) The Illinois Department, comprehensive providers and participating downstate units shall make referrals to the Earnfare program as follows:

A) Any person may request a referral.

B) Exempt and nonexempt food stamp individuals and individuals not receiving food stamps who are non-custodial parents of AFDC children may be ordered by a court of competent jurisdiction to participate in the Earnfare Component.

C) Within 30 days after a request for an Earnfare referral:

i) persons who do not qualify for the Earnfare program shall be given or sent a notice informing them that they do not qualify and will not receive a referral;

ii) persons who request a referral and who qualify for the Earnfare program shall be provided with a written document that acknowledges the request and informs the individual that he/she is qualified.

3) Within 30 days after notice of eligibility, individuals shall be assessed and referred to appropriate Earnfare slots, if slots are available.

e) For the purposes of Earnfare, a "suitable" Earnfare slot must meet the following requirements:

1) there are no questions as to the individual's ability to engage in such employment for medical reasons or because the individual has no way to get to or from the particular job;

2) there are no questions of working conditions, such as risks to health, safety, or lack of worker's compensation protection;

3) the individual may not be required, as a condition of employment, to join, resign from, or refrain from joining any legitimate labor organization;

4) there is no unreasonable degree of risk to the individual's health and safety; and

5) the individual is physically and mentally competent to perform the work.

f) Individuals participating in Earnfare shall not displace or substitute for regular, full-time or part-time employees, regardless of whether the employee is currently working, on a leave of absence, or in a

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position or similar position where a layoff has taken place or the employer has terminated the employment of any regular employee or otherwise reduced its work force with the effect of filling the vacancy so created with an individual subsidized under this program, or is or has been involved in a labor dispute between a labor organization and the sponsor.

g) Entry into the Component

1) Individuals shall be referred to suitable Earnfare slots with local governmental units, not-for-profit community based and local organizations, other public agencies, including State agencies, and with private employers.

2) To the extent appropriate slots are available, individuals will be referred to suitable Earnfare activities based on an assessment of the individual's age, literacy, education, educational achievement, job training, work experience, and recent institutionalization, whenever these factors are known and are relevant to the individual's success in carrying out the assigned activities and in ultimately obtaining employment. The Department or the participating local governmental unit shall discuss with the individual available Earnfare assignments, together with any restrictions and qualifications the Earnfare employers have specified for the assignments. The individual's personal preferences for available Earnfare assignments and the individual's employment goals shall be ascertained and considered in making the Earnfare referral.

3) The Department, comprehensive providers and local governmental units shall maintain up-to-date public listings by area of Earnfare employers and current information regarding openings in those projects. These listings and the information shall be available to the public, in writing or by phone, during regular business hours.

h) Payments

1) Individuals participating in Earnfare shall engage in hours of work equal to the amount of the food stamp benefits divided by the federal minimum wage up to a maximum of 26 hours and subsequently shall earn assistance at minimum wage for each additional hour of performance in Earnfare activity, up to a maximum of $231.00 per month. An individual is considered to have participated in Earnfare in any month he or she earns a payment. If a court of competent jurisdiction orders an individual to participate in the Earnfare program, hours engaged in employment-assigned activities multiplied by the minimum wage shall first be applied as a $50.00 payment made to the custodial parent as a support obligation. If the individual receives food stamps, the individual shall engage in hours of employment-assigned activities equal to the amount of the food stamp benefits divided by the federal minimum wage up to a maximum of 26 hours and subsequently shall earn assistance at

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minimum wage for each additional hour of performance in Earnfare activity. The individual can earn a maximum of $231.00 each month including the amount of the support obligation. Individuals will be assigned hours of Earnfare based upon their initial food stamp authorization amount. An individual living in a multi-person food stamp household shall be deemed to be receiving a per capita share of the household's food stamp allotment, for purposes of calculating the Earnfare hours. During an individual's Earnfare participation, the Department or the local governmental unit shall alter the Earnfare hours each time the individual's monthly food stamp benefit changes by at least $20.00, effective the same month as the change in the food stamp benefit. Individuals and contractors will be notified by the Department or the local governmental unit of the number of hours of work to be performed by an individual in Earnfare.

2) Individuals remain financially eligible for Earnfare and Earnfare job search activity so long as they receive food stamps. Receipt of food stamps is not an eligibility requirement of Earnfare when a court of competent jurisdiction orders an individual to participate who is a non-custodial parent of AFDC children.

3) The Department may pay participants directly or may contract for the Earnfare employer to pay the individual. Payments shall be made no less frequently than monthly. Individuals shall be paid only for the hours they have actually worked in excess of the food stamp hours of work obligation and, if ordered by a court of competent jurisdiction, in excess of food stamp hours and the support obligation.

4) Individuals shall be credited with hours of work that the Earnfare employer certifies them to have completed, according to criteria set forth in the contract with the Illinois Department, comprehensive providers or the local governmental unit. The Department, comprehensive providers or the local governmental unit staff shall attempt to resolve disputes between the Earnfare employer and the individual when there is disagreement over the number of hours worked. If the dispute cannot be resolved, the individual may utilize the Illinois Department's appeal process.

5) The Illinois Department or the provider shall, in advance, provide individuals participating in Earnfare who need transportation with the cost of transportation in getting to and from the Earnfare site and to Earnfare participants who are not in the job search component for specific job interviews arranged by their Earnfare employer. Individuals obtaining unsubsidized employment while participating in Earnfare may be eligible for initial employment expenses as stated in Section 121.188.

6) Participants in the Earnfare job search activity are eligible for employer contact related expenses not to exceed $20.00 every 30 days for a maximum of two months in a 12 consecutive month period.

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7) The Illinois Department will provide necessary clothing to enable participants to report to their Earnfare job site. Participants will be required to submit a written request for clothing needed.

i) Participation Requirements

1) Individuals may volunteer to participate in Earnfare and participation shall be limited to only six months out of any 12 consecutive month period except that court-ordered participants shall participate for six months unless the court orders participation for less than six months out of any 12 consecutive month period. Individuals participating in Earnfare shall engage in hours of work equal to the amount of the food stamp benefits divided by the federal minimum wage up to a maximum of 26 hours and subsequently shall earn assistance at minimum wage for each additional hour of work up to a maximum of $231.00 per month. If a court of competent jurisdiction orders an individual to participate in the Earnfare program, hours engaged in employment-assigned activities multiplied by the minimum wage shall first be applied as a $50.00 payment made to the custodial parent as a support obligation. If the individual receives food stamps, the individual shall engage in hours of employment-assigned activities equal to the amount of the food stamp benefits divided by the federal minimum wage up to a maximum of 26 hours and subsequently shall earn assistance at minimum wage for each hour of performance in Earnfare activity up to $231.00 including the amount of the support obligation. Individuals participating in Earnfare first work the number of hours equal to food stamp benefits and subsequently earn financial assistance benefits.

2) Individuals are required to report as scheduled and on time to their Earnfare employer when notified of a referral. When they cannot report to their Earnfare assignment or if they will be late, they are to immediately notify their Earnfare employer.

3) If the individual demonstrates an inability to sustain the work that has been assigned and the Earnfare assignment was appropriate to the individual's abilities, the Illinois Department shall re-assess the individual and, if appropriate, shall refer the person to apply for Transitional Assistance or Interim Assistance and federal SSI benefits. If the person is ordered by a court of competent jurisdiction to participate in the Earnfare Component, that person shall also be referred back to the court when unable to perform the work that has been assigned.

4) An individual may be dismissed by the employer from an Earnfare assignment prior to its completion. The Department, comprehensive providers or local governmental unit shall return an individual dismissed by an employer to the client pool. An individual dismissed by an employer shall be treated as a new program entrant for the purpose of Earnfare assignments. A

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dismissal from an Earnfare assignment shall not cause a food stamp sanction.

5) During Earnfare assignment, individuals are required to accept bona fide offers of suitable employment pursuant to Section 121.162(c)(4).

6) During the Earnfare assignment participants are required to apply for suitable jobs for which the provider makes a referral.

7) Earnfare clients may participate in a voluntary job search activity as resources permit. There are no sanctions for failure to comply. Earnfare clients may participate for two months in a 12 consecutive month period, either concurrently or following the six-month eligibility period for Earnfare. Clients are required to make a minimum of 20 employer contacts each month while in the Earnfare job search activity.

(Source: Amended at 20 Ill. Reg. 11935, effective AUG 14 1996)

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1) Heading of the Part: Child Health Examination Code

2) Code Citation: 77 Ill. Adm. Code 665

3)

Section Numbers:	Adopted Action:
665.210	Amendment
665.230	Amendment
665.240	Amendment
665.250	Amendment
665.510	Amendment
665.Appendix B	New Section

4) Statutory Authority: Implementing and authorized by Section 27-8.1 of the School Code [105 ILCS 5/27-8.1].

5) Effective Date of Amendments: August 15, 1996

6) Does this Rulemaking Contain an Automatic Repeal Date? No

7) Does this Rulemaking Contain an Incorporation by Reference? Yes

8) Date Filed in Agency's Principal Office: August 15, 1996

9) Date Notice of Proposed Amendments was Published in the Illinois Register: 20 Ill. Reg. 4894 - March 29, 1996

10) Has the Joint Committee on Administrative Rules Issued a Statement of Objection to this Rulemaking: No

11) Difference Between Proposal and Final Version: In Section 665.240, as proposed, the programs defined as school programs below the kindergarten level included "early intervention programs serving children at home". This type of program was deleted from the rulemaking at second notice, leaving programs defined as school programs below the kindergarten level to include nursery schools, pre-school programs, early childhood programs, Head Start and other pre-kindergarten programs offered by a school or school district.

Section 665.240(g) was revised at second notice to require children entering the 8th grade for the first time after July 1997, to show evidence of having received 3 doses of hepatitis B vaccine. The first two doses must have been received no less than 4 weeks apart, and the interval between the second and third dose must be at least two months. Proof of prior or current infection, if verified by laboratory evidence, may be substituted for proof of vaccination.

12) Have all the changes agreed upon by the Agency and the Joint Committee been made as indicated in the agreement letter issued by the Joint

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Committee? All changes requested by the Joint Committee on Administrative Rules have been made.

13) Will the Rulemaking Replace an Emergency Rule Currently in Effect? No

14) Are there any other Amendments Pending on this Part? No

15) Summary and Purpose of Rulemaking: This rulemaking adds mumps, Haemophilus influenza type b, and hepatitis B to the list of immunizations that a child must present prior to entering a school program. School programs below the kindergarten level are defined to include nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district. The amendments also require children entering the 5th grade for the first time after July of 1997 to show evidence of having received 3 doses of hepatitis B vaccine. The amendments provide additional detail concerning objection of parents to immunizations on religious grounds.

16) Information and Questions Regarding this Adopted Rulemaking Should be Directed to:

Gail M. DeVito
Division of Governmental Affairs
Illinois Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, IL 62761
(217) 782-6187

The full text of the Proposed Rule(s) begins on the next page:

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TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER i: MATERNAL AND CHILD HEALTH

PART 665
CHILD HEALTH EXAMINATION CODE

SUBPART A: GENERAL PROVISIONS

SUBPART B: HEALTH EXAMINATION

SUBPART C: VISION AND HEARING SCREENING

SUBPART D: DENTAL EXAMINATION

SUBPART E: EXCEPTIONS

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SUBPART F: VISION EXAMINATION

Section
665.610 Vision Examination Recommendation
665.620 Vision Examination
665.630 Vision Examination Report
665.640 Indigent Students

APPENDIX A Vision Examination Report
APPENDIX B Vaccination Schedule for Haemophilus influenzae type b Conjugate Vaccines (Hib) ~~Certificate of Child Health Examination Repealed~~

AUTHORITY: Implementing and authorized by Section 27-8.1 of the School Code [105 ILCS 5/27-8.1] and Section 6.2 of the Lead Poisoning Prevention Act [410 ILCS 45/6.2].

SOURCE: Emergency rule adopted at 4 Ill. Reg. 38, p. 275, effective September 10, 1980, for a maximum of 150 days; emergency rule adopted at 4 Ill. Reg. 41, p. 176, effective October 1, 1980, for a maximum of 150 days; adopted at 5 Ill. Reg. 1403, effective January 29, 1981; codified at 8 Ill. Reg. 8921; amended at 11 Ill. Reg. 11791, effective June 29, 1987; amended at 13 Ill. Reg. 11565, effective July 1, 1989; amended at 13 Ill. Reg. 17047, effective November 1, 1989; emergency amendment at 14 Ill. Reg. 5617, effective March 30, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14543, effective August 27, 1990; amended at 15 Ill. Reg. 7706, effective May 1, 1991; amended at 18 Ill. Reg. 4296, effective March 5, 1994; amended at 20 Ill. Reg. 11950, effective AUG 15 1996.

SUBPART B: HEALTH EXAMINATION

Section 665.210 Proof of Immunizations

Every child shall present, on or about the same time as he/she receives a health examination, proof to the local school authority of having received such immunizations as the Department shall require in Section 695.10 of the ~~School Child~~ Immunization Code (77 Ill. Adm. Code 695).

(Source: Amended at 20 Ill. Reg. 11950, effective AUG 15 1996)

Section 665.230 School Entrance

a) Every child, prior to enrolling in ~~entering~~ any public, private independent or parochial school (includes nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) in Illinois shall present to that school proof of

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immunity against:
1) Diphtheria
2) Pertussis
3) Tetanus
4) Poliomyelitis
5) Measles
6) Rubella
7) Mumps
8) Haemophilus influenzae type b (as noted in Section 665.240(f))
9) Hepatitis B (as noted in Section 665.240(g))

b) The health care provider verifying the administration of the required immunization shall record as indicated on the Certificate of Child Health Examination that the immunizations were administered.

c) Any child who does not submit proof of having protection by immunity as required must receive the needed vaccine. If for medical reasons one or more of the required immunizations must be given after the date of entrance of the current school year, a schedule for the administration of the immunizations and a statement of the medical reasons causing the delay must be signed by the health care provider who will administer the needed immunizations and be kept on file at the local school.

~~d) All children currently enrolled in school in Illinois who are susceptible to mumps must show proof of immunity prior to entering for school.~~

(Source: Amended at 20 Ill. Reg. 11950, effective AUG 15 1996)

Section 665.240 Basic Immunization

a) Diphtheria, Pertussis, Tetanus

1) Any child 2 years of age or older entering school (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) must show proof (see Section 665.230(b)) of having received four or more doses of Diphtheria, Tetanus, Pertussis (DTP) vaccine. Individual doses in the series must have been received no less than four weeks apart. The interval between the third and fourth or final dose must be at least six months.

2)~~1~~ Any child 5 years of age or younger entering school, kindergarten or first grade, for the first time must show proof (see Section 665.230(b)) of having received four or more doses of Diphtheria, Tetanus, Pertussis (DTP) ~~Pertussis, Tetanus DPT,~~ with the last dose being a booster and having been received on or after the 4th birthday, but prior to school entrance ~~or within one year prior to school entrance~~. Individual doses in the series must have been received no less than four weeks apart.

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The interval between the third and fourth or final dose must be at least six months. Children six years of age and older may receive Tetanus, Diphtheria (Td) vaccine in lieu of DTP Vaccine. Pertussis vaccine is not medically recommended for children 7 years of age or older.

3)~~2~~ Any child entering school at a grade level not included in subsection (a)(1) or (2) of this Section 6-years-of-age-or-older must show proof (see Section 665.250(b)) of receiving three or more doses of DTP DPT or Tetanus, Diphtheria (Td) with the last dose being a booster and having been received on or after the 4th birthday. Individual doses in the series must have been received no less than four weeks apart.

4)~~3~~ If 10 years have elapsed since the last booster, an additional Td booster is required.

b) Polio

1) Any child 2 years of age or older entering school (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) must show proof (see Section 665.250(b)) of having received three or more doses of Trivalent Oral Polio Vaccine (TOPV). Individual doses in the series must have been received no less than six weeks apart.

2)~~1~~ Any child 5 years of age or younger entering school, kindergarten or first grade, for the first time must show proof (see Section 665.250(b)) of having received three or more doses of Trivalent Oral ~~or~~ Polio Vaccine (TOPV) with the last dose being a booster and having been received on or after the 4th birthday, but prior to school entrance. The first two ~~individual~~ doses in the series must have been received no less than six weeks apart. The interval between the second and third or final dose must be at least six months.

3)~~2~~ Any child entering school at a grade level not included in subsection (b)(1) or (2) of this Section 6-years-of-age-or-older must show proof (see Section 665.250(b)) of receiving three or more doses of the TOPV with the last dose being a booster and having been received on or after the 4th birthday. The first two ~~individual~~ doses in the series must have been received no less than six weeks apart. The interval between the second and third or final dose (booster dose) must be at least six months.

4)~~3~~ A series of enhanced-potency inactivated polio vaccine (e-IPV) or inactivated polio virus vaccine (IPV) and appropriate boosters may, for an individual, be substituted for vaccination with TOPV at the direction of a physician.

c) Measles

1) Any child 2 years of age or older entering school (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) must show proof (see

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Section 665.250(b)) of having received one dose of live measles virus vaccine at 12 months of age or older, or other proof of immunity described in Section 665.250(c).

~~1) Children who have had measles or have been immunized with one dose of live measles virus vaccine on 15 months of age or older or children who have had two doses of live measles virus vaccines the first dose at least 12 months of age and the second dose no less than 1 month after the first shall be considered protected and in compliance.~~

2) Children entering ~~the 5th grade for the first time after July of 1990, entering the 8th grade for the first time after July of 1991, and entering~~ at any grade level, K-12, must ~~after July of 1993~~ ~~will be required to~~ show evidence of having received two doses of live measles virus vaccine, the first dose at ~~least~~ 12 months of age or older and the second dose no less than 1 month after the first or other proof of immunity described in Section 665.250(c) ~~this~~ Part.

~~3) Any child two years of age or older who is entering at a grade level in which evidence of two doses of live measles virus vaccine is not required, shall show proof (see Section 665.250(b)) of receiving measles vaccine on 15 months of age or older. Immunization at 12 months of age or older is acceptable for those students who entered kindergarten or first grade prior to the 1981-1982 school year. Proof of disease, if verified by a physician licensed to practice medicine in all of its branches may be substituted for proof of vaccination (see Section 665.250(c)).~~

~~4) If immunization was received prior to 1968, proof must be provided that a live virus vaccine was given.~~

3)~~5~~ For students attending school programs where grade levels (K-12) are not assigned, including special education programs, proof of two doses of live virus measles vaccine as described in (c)(2) shall be submitted prior to the school year in which the child reaches the ages of 5, 10, and 15.

d) Rubella-Mumps

~~1) Any child All children~~ 2 years of age or older entering school at any grade level, including nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district, must show proof (see Section 665.250(b)) of receiving at least one dose of rubella vaccine at 12 months of age or older on or after one ~~the~~ last ~~birthday~~. Proof of disease is not acceptable unless laboratory evidence of rubella immunity is presented (see Section 665.250(d)) ~~with blood titer of 1:10 or equivalent titer) or greater.~~

~~2) Any child two years of age or older entering at any grade level must show proof (see Section 665.250(b)) of receiving mumps vaccine at 12 months of age or older. Proof (dates) of disease, if verified by a physician, licensed to practice medicine in all~~

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~~of its branches may be substituted for proof of vaccination~~

e) Mumps
Any child 2 years of age or older entering school at any grade level, including nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district must show proof (see Section 665.250(b)) of receiving at least one dose of mumps vaccine at 12 months of age or older. Proof of disease, if verified by a physician licensed to practice medicine in all of its branches, or laboratory evidence of mumps immunity may be substituted for proof of vaccination (see Section 665.250(e)).

f) Haemophilus influenzae type b
1) Any child 2 years of age or older entering school (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) must show proof of immunization that complies with the Hib vaccination schedule in Appendix B of this Part.
2) Children 24-59 months of age who have not received the primary series of Hib vaccine, according to the Hib vaccination schedule, must show proof of receiving one dose of Hib vaccine at 15 months of age or older.
3) Any child 5 years of age or older shall not be required to provide proof of immunization with Hib vaccine.

g) Hepatitis B
1) Any child 2 years of age or older entering school (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) after July 1997 must show proof (see Section 665.250(b)) of having received three doses of hepatitis B vaccine. The first two doses must have been received no less than 4 weeks apart, and the interval between second and third dose must be at least two months. Proof of prior or current infection, if verified by laboratory evidence, may be substituted for proof of vaccination (see Section 665.250(f)).
2) Children entering the 5th grade for the first time after July 1997, must show evidence of having received 3 doses of hepatitis B vaccine. The first two doses must have been received no less than 4 weeks apart, and the interval between the second and third dose must be at least two months. Proof of prior or current infection, if verified by laboratory evidence, may be submitted for proof of vaccination (see Section 665.250(f)).

(Source: Amended at 20 Ill. Reg. 11950, effective AUG 15 1996)

Section 665.250 Proof of Immunity

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a) Proof of immunity shall be documented evidence of having received vaccine or proof of disease (as described below) verified by a health care provider defined as: physician (see Section 665.130), school health professional, or health official.
b) Day and month is required if it can not otherwise be determined that the vaccine was given after the minimum interval or age.
c) Proof of prior measles disease must be verified with date of illness signed by a physician or laboratory evidence of measles immunity ~~by an antibody titer of 1:16 (or equivalent titer) or greater~~.
d) The only acceptable proof of immunity for rubella is evidence of vaccine (dates, see subsection (b) above) or laboratory evidence of rubella immunity ~~a blood titer of 1:16 (or equivalent titer) or greater~~.
e) Proof of prior mumps disease must be verified with date of illness signed by a physician or laboratory evidence of mumps immunity. Laboratory evidence of mumps immunity is only acceptable if the diagnostic test utilized to assess immunity is one with demonstrable reliability, including neutralization, enzyme-linked immunosorbent assay (ELISA or EIA), or radial hemolysis antibody test. A four-fold rise in mumps antibody titer between appropriately spaced acute and convalescent sera is also acceptable as proof of immunity.
f) Proof of prior or current hepatitis B infection must be verified by laboratory evidence. Laboratory evidence of prior or current hepatitis B infection is only acceptable if one of the following serologic tests indicates positivity: HBsAg, anti-HBc and/or anti-HBs.

(Source: Amended at 20 Ill. Reg. 11950, effective AUG 15 1996)

SUBPART E: EXCEPTIONS

Section 665.510 Objection of Parent or Legal Guardian

Parent or legal guardian of a student may object to health examinations, immunizations, vision and hearing screening tests, and dental health examinations for their children on religious grounds. If a religious objection is made, a written and signed statement from the parent or legal guardian detailing such objections must be presented to the local school authority. The objection must set forth the specific religious belief which conflicts with the examination, immunization or other medical intervention. The religious objection may be personal and need not be directed by the tenets of an established religious organization. General philosophical or moral reluctance to allow physical examinations, immunizations, vision and hearing screening, and dental examinations will not provide a sufficient basis for an exception to statutory requirements. The local school authority is responsible for determining whether the written statement constitutes a valid religious objection. The parent or legal guardian must be informed by the local school

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authority of measles outbreak control exclusion procedures in accordance with the Department's rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690) at the time such objection is presented.

(Source: Amended at 20 Ill. Reg. 11950, effective AUG 15 1996)

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Section 665.APPENDIX B Vaccination Schedule for Haemophilus influenzae type b Conjugate Vaccines (Hib) ~~Certificate of Child Health Examination (Repealed)~~

Vaccine	Age at 1st dose (mos.)	Primary series	Booster	Total number of doses for series
HbOC/PRP-T	2-6	3 doses,2mo.apart(a)	12-15 mo.(b)(c)	4
HibTITER(TM)	7-11	2 doses,2mo.apart(a)	12-18 mo.(b)(c)	3
ActHib(e)(TM)	12-14	1 dose	15 mo.,b)(c)	2
	15-59	1 dose(d)	None	1
OmniHib(TM)				
TETRAMUNE(TM)				
PRP-OMP	2-6	2 doses,2mo.apart(a)	12 mo.(b)(c)	3
	7-11	2 doses,2mo.apart(a)	12-18 mo.(b)(c)	3
PedvaxHIB(TM)	12-14	1 dose	15 mo.,b)(c)	2
	15-59	1 dose(d)	None	1
PRP-D	15-59	1 dose(c)(d)	None	1
ProHIBIT(TM)				

(a) Minimally acceptable interval between doses is one month

(b) At least two months after previous dose

(c) After the primary infant Hib vaccine series is completed, any of the licensed Hib conjugate vaccines may be used as a booster dose

(d) Children 15-59 months of age should receive only a single dose of Hib vaccine

(e) Reconstituted with DTP as a combined DTP/Hib vaccine

(TM) Trademark

Note: A DTP/Hib combination vaccine can be used in place of HbOC or PRP-T

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(Source: Section repealed at 18 Ill. Reg. 4296, effective March 5, 1994; new Section adopted at 20 Ill. Reg. 11950, effective AUG 15 1996)

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NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Immunization Code

2) Code Citation: 77 Ill. Adm. Code 695

3)

Section Numbers:	Adopted Action:
695.10	Amendment
695.30	Amendment
695.50	Amendment
665.Appendix A	New Section

4) Statutory Authority: Implementing and authorized by the Communicable Disease Prevention Act [410 ILCS 315], Section 27-8.1 of the School Code [105 ILCS 5/27-8.1], and the Child Care Act of 1969 [225 ILCS 10/7].

5) Effective Date of Amendments: August 15, 1996

6) Does this Rulemaking Contain an Automatic Repeal Date? No

7) Does this Rulemaking Contain an Incorporation by Reference? Yes

8) Date Filed in Agency's Principal Office: August 15, 1996

9) Date Notice of Proposed Amendments was Published in the Illinois Register: 20 Ill. Reg. 4906 - March 29, 1996

10) Has the Joint Committee on Administrative Rules Issued a Statement of Objection to this Rulemaking: No

11) Difference Between Proposal and Final Version: In Section 695.10, as proposed, the programs defined as school programs below the kindergarten level included "early intervention programs serving children at home". This type of program was deleted from the rulemaking at second notice, leaving programs defined as school programs below the kindergarten level to include nursery schools, pre-school programs, early childhood programs, Head Start and other pre-kindergarten programs offered by a school or school district.

Section 695.10(j) was revised at second notice to require children entering the 5th grade for the first time after July 1997, to show evidence of having received 3 doses of hepatitis B vaccine. The first two doses must have been received no less than 4 weeks apart, and the interval between the second and third dose must be at least two months. Proof of prior or current infection, if verified by laboratory evidence, may be substituted for proof of vaccination.

12) Have all the changes agreed upon by the Agency and the Joint Committee been made as indicated in the agreement letter issued by the Joint Committee? All changes requested by the Joint Committee on Administrative

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Rules have been made.

13) Will the Rulemaking Replace an Emergency Rule Currently in Effect? No

14) Are there any other Amendments Pending on this Part? No

15) Summary and Purpose of Rulemaking: This rulemaking adds hepatitis B to the list of basic immunizations and prescribes the optimum starting age for the immunization as birth - 2 months. School is defined, for the purposes of requiring compliance with the recommended immunization schedule, to include nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district. The amendments change the recommended age for the first measles and mumps vaccine from 15 months to 12 months. Proof of a second dose of measles vaccine will be required for children entering school at any grade level K-12, instead of at 5th grade, as is the current requirement. The amendments provide additional detail concerning objection of parents to immunizations on religious grounds.

This rulemaking adds mumps, Haemophilus influenza type b, and hepatitis B to the list of immunizations that a child must present prior to entering a school program. School programs below the kindergarten level are defined to include nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district. The amendments also require children entering the 5th grade for the first time after July of 1997 to show evidence of having received 3 doses of hepatitis B vaccine. The amendments provide additional detail concerning objection of parents to immunizations on religious grounds.

16) Information and Questions Regarding this Adopted Rulemaking Should be Directed to:

Gail M. DeVito
Division of Governmental Affairs
Illinois Department of Public Health
535 West Jefferson, Fifth Floor
Springfield, Illinois 62761
(217) 782-6187

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER k: COMMUNICABLE DISEASE CONTROL AND IMMUNIZATIONS

PART 695
IMMUNIZATION CODE

Section
695.10 Basic Immunization
695.20 Booster Immunizations
695.30 Exceptions
695.40 List of Non-Immunized Child Care Facility Attendees or Students
695.50 Proof of Immunity
APPENDIX A Vaccination Schedule for Haemophilus influenzae type b Conjugate Vaccines (Hib) ~~+Hb€V}~~

AUTHORITY: Implementing and authorized by the Communicable Disease Prevention Act [410 ILCS 315], Section 27-8.1 of the School Code [105 ILCS 5/27-8.1], and Section 7 of the Child Care Act of 1969 [225 ILCS 10/7].

SOURCE: Emergency amendment effective June 23, 1977; emergency amendment at 3 Ill. Reg. 14, p. 88, effective March 21, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 52, p. 134, effective December 17, 1979; codified at 8 Ill. Reg. 4512; amended at 11 Ill. Reg. 11799, effective June 29, 1987; emergency amendment at 14 Ill. Reg. 5890, effective March 30, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14562, effective August 27, 1990; amended at 15 Ill. Reg. 7712, effective May 1, 1991; amended at 17 Ill. Reg. 2975, effective February 11, 1993; amended at 20 Ill. Reg. 11962, effective AUG 15 1996.

NOTE: In this Part, superscript numbers or letters are denoted by parentheses; subscript are denoted by brackets.

Section 695.10 Basic Immunization

a) The optimum starting ages for the specified immunizing procedures are as follows:

1)	Diphtheria	2-4 months
2)	Pertussis	2-4 months, combined with diphtheria-tetanus toxoid
3)	Tetanus	2-4 months
4)	Poliomyelitis	2-4 months
5)	Measles	12-15 months
6)	Rubella	12-15 months
7)	Mumps	12-15 months
8)	Haemophilus influenzae type b	2-4 months
9)	Hepatitis B	Birth-2 months

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b) All children 2 months of age and over upon first entering a child care facility shall present evidence that such person has been immunized, or is in the process of being immunized, according to the recommended schedule against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, ~~and~~ Haemophilus influenzae type b, and hepatitis B.

c) All children entering school programs (includes nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) in Illinois for the first time shall present evidence of immunity against:

1) Diphtheria
2) Pertussis (except as noted in ~~under~~ subsection (d) of this Section)
3) Tetanus
4) Poliomyelitis
5) Measles except as noted in ~~under~~ subsection (f) ~~(h)~~ of this Section ~~below~~)
6) Rubella
7) Mumps
8) Haemophilus influenzae type b (except as noted in subsection (i) of this Section)
9) Hepatitis B except as noted in subsection (j) of this Section)

~~d) Any child under 6 years of age who has not been immunized against diphtheria, pertussis and tetanus shall receive 3 injections of diphtheria-pertussis-tetanus combined antigen separated by intervals of 4 weeks or more. Pertussis (whooping cough) vaccine is medically contraindicated for children over the age of 6 years.~~

~~e) Any child 6 years of age or over not having been immunized against diphtheria or tetanus shall receive 2 injections of diphtheria-tetanus separated by intervals of 4-6 weeks or more, with a reinforcing dose at least 6 months after second.~~

d)~~f)~~ Diphtheria, Tetanus, Pertussis ~~Pertussis, Tetanus~~

1) Any ~~non-school-age~~ child entering a child care facility or school program under the kindergarten level (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) must show proof (see Section 695.50) of having received three doses of Diphtheria, Tetanus, Pertussis (DTP) ~~Pertussis, Tetanus (DPT)~~ by one year of age and one additional dose by the second birthday. Individual doses in the series must have been received no less than four weeks apart. The interval between the third and fourth or final dose must be at least 6 months. Any child 24 months of age or older shall present proof of four doses of DTP ~~DPT~~ vaccine, appropriately spaced.

2) Any child ~~5 years of age or younger~~ entering school, kindergarten or first grade, for the first time must show proof (see Section 695.50) of having received four or more doses of Diphtheria, Tetanus, Pertussis (DTP) ~~Pertussis, Tetanus (DPT)~~ with the last dose being a booster and having been received on or after the 4th birthday, but prior to school entrance~~, or within one year prior to school entrance~~. Individual doses in the series must have been received no less than four weeks apart. The interval between the third and fourth, or final dose, must be at least 6 months. Children six years of age or older may receive Tetanus, Diphtheria (Td) vaccine in lieu of DTP vaccine. Pertussis vaccine is not medically recommended for children 7 years of age or older.

3) Any child entering school at a grade level not included in subsection (d)(1) or (2) of this Section ~~6 years of age or older~~ must show proof (see Section 695.50) of having received three or more doses of DTP ~~DPT~~ or Tetanus, Diphtheria (Td) with the last dose being a booster and having been received on or after the 4th birthday. Individual doses in the series must have been received no less than four weeks apart. The interval between the second and third, or final dose, must be at least 6 months.

4) If 10 years have elapsed since the last booster, an additional Td booster is required.

5) School age children entering a child care facility shall comply with the immunization requirements in accordance with subsections (d)(2), (3) and (4) above.

e)~~g)~~ Polio

1) Any ~~non-school-age~~ child entering a child care facility or school program under the kindergarten level (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district must show proof (see Section 695.50) of having received two doses of Trivalent Oral Polio Vaccine ~~trivalent live oral polio vaccine~~ (TOPV) by one year of age and a third dose by the second birthday. Individual doses in the series must have been received no less than 6 weeks apart. ~~The interval between the second and third, or final dose, must be at least 6 months.~~ Any child 24 months of age or older shall present proof of at least three doses of TOPV, appropriately spaced.

2) Any child entering school at any grade level, K-12, must show proof (see Section 695.50) of having received three or more doses of Trivalent Oral Polio Vaccine (TOPV) with the last dose being a booster and having been received on or after the 4th birthday, but prior to school entrance. The first two doses in the series must have been received no less than six weeks apart. The interval between the second and third or final dose must be at least six months. ~~If the child has received primary immunization against polio with live oral polio vaccine, a booster dose of trivalent live oral polio vaccine shall be administered prior to his or her entrance to kindergarten or first grade. Any child~~

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~~not having received primary immunization against polio with live oral polio vaccine shall receive 2 doses (no less than six weeks apart) of trivalent live oral polio vaccine prior to entering kindergarten or first grade and a booster at least 6 months after the second.~~

3) A course of enhanced-potency inactivated polio ~~poliovirus~~ vaccine (e-IPV) or inactivated polio vaccine (IPV) and appropriate boosters may, for an individual child, be substituted for vaccination with Trivalent Oral Polio Vaccine (TOPV) ~~live oral polio virus vaccine~~ at the direction of a physician licensed to practice medicine in all its branches.

4) School age children entering a child care facility shall comply with the immunization requirements in accordance with subsections (e)(2) and (3) above.

f)h) Measles

1) Any non-school-age child entering a child care facility or school program under the kindergarten level (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) shall present evidence of having received one dose of live measles virus vaccine by the second birthday. The measles vaccine must have been received at 12 ~~15~~ months of age or older. ~~A child immunized with live measles virus vaccine at twelve months of age or older who resides in an area identified by the Department as high risk for measles at the time of vaccine administration may be considered protected and in compliance.~~

2) The child shall present evidence that he or she has:

A) been age-appropriately immunized against red measles (rubeola) prior to entering a child care facility or school, including school programs under the kindergarten level, for the first time, or

B) a statement from the physician that he or she has had measles (rubeola), or

C) laboratory evidence of measles immunity.

~~3) Children who have had measles or have been immunized with one dose of live measles virus vaccine who is months of age or older or children who have had two doses of live measles virus vaccine; the first dose at least 12 months of age and the second dose no less than 1 month after the first, shall be considered protected and in compliance. At the discretion of a physician licensed to practice medicine in all its branches, a child immunized with live measles virus vaccine at 12 months of age or older who first enters school in Illinois between August 1997 and September 1998, may be considered protected and in compliance.~~

3)4) Children entering school at the 9th grade for the first time after July of 1990, entering the 9th grade for the first time after July of 1991, and entering any grade level, K-12, must

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after July of 1993, will be required to show evidence of having received two doses of live measles virus vaccine, the first dose at least 12 months of age or older and the second dose no less than 1 month after the first or other proof of immunity as described in this Part.

4)5) For students attending school programs where grade levels (K-12) are not assigned, including special education programs, proof of two doses of measles vaccine as described in subsection (f)(3) of this Section ~~h)3)~~ shall be submitted prior to the school year in which the child reaches the ages of 5, 10, and 15.

5)6) School age children entering a child care facility shall comply with the immunization requirements in accordance with subsections (f)(2), (3), and (4) ~~and 4)~~ above.

g)i) Mumps

1) Any non-school-age child entering a child care facility or school program under the kindergarten level (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) shall present evidence of having received one dose of live mumps virus vaccine on the second birthday. The mumps vaccine must have been received at twelve (12) months of age or older ~~(preferably at fifteen (15) months of age or older)~~.

2) The child shall present evidence that he or she has:

A) been age-appropriately immunized against mumps prior to entering a child care facility or school, including school programs under the kindergarten level, for the first time, or

B) a statement from the physician that he or she has had mumps, or

C) laboratory evidence of mumps immunity (see Section 695.50(e)).

3) Children entering school at any grade level, K-12, must show evidence of having received at least one dose of mumps vaccine at 12 months of age or older.

4)3) Only those children who have ~~had mumps or have~~ been immunized with live mumps virus vaccine at twelve (12) months or older, had physician diagnosed mumps disease, or show laboratory evidence of immunity shall be considered to be immune.

~~4) All children currently enrolled in school in Illinois who are susceptible to mumps must show proof of immunity prior to enrolling for school year 1987-88.~~

5) School age children entering a child care facility shall comply with the immunization requirements in accordance with subsections (g)(2), (3) and (4) above.

h)j) Rubella

1) Any non-school-age child entering a child care facility or school program under the kindergarten level (defined as nursery schools,

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pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) shall present evidence of having received one dose of rubella vaccine by the second birthday. The rubella vaccine must have been received at twelve (12) months of age or older ~~(preferably at fifteen (15) months of age or older)~~.

2) The child shall present evidence that he or she has:

A) been age-appropriately immunized against rubella prior to entering a child care facility or school, including school programs under the kindergarten level, for the first time, or

B) laboratory evidence of immunity to rubella ~~a blood titer of 1:16 for equivalent titer) or greater~~.

3) Children entering school at any grade level, K-12, must show evidence of having received at least one dose of rubella vaccine at 12 months of age or older.

4) ~~3)~~ Only those children who have ~~laboratory (serologic) evidence of rubella immunity or have~~ been immunized with rubella vaccine at twelve (12) months or older, or have a laboratory (serologic) evidence of immunity to rubella, shall be considered to be immune.

5) ~~4)~~ School age children entering a child care facility shall comply with immunization requirements in accordance with subsections (h)(2), and (3) and (4) above.

i) ~~k)~~ Haemophilus influenzae type b (Hib)

1) Any child under 5 years of age entering a child care facility or school program under the kindergarten level (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) shall present evidence of immunization that complies with the Hib vaccination schedule in Appendix A of this Part. Any child who has reached his fifth birthday shall not be required to present evidence of immunization.

2) Children 24-59 months of age who have not received the primary series of Hib vaccine, according to the Hib vaccination schedule, must show proof of receiving one dose of Hib vaccine at 15 months of age or older.

j) Hepatitis B

1) Any child 2 years of age or older enrolling in a child care facility or school program under the kindergarten level (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) after July 1997 shall present evidence of having received 3 doses of hepatitis B vaccine. The first two doses must have been received no less than 4 weeks apart, and the interval between the second and third dose must be at least two months. The child

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shall present evidence that he or she has:

A) been age-appropriately immunized against hepatitis B prior to enrolling in a child care facility or school program under the kindergarten level for the first time, or

B) laboratory evidence of prior or current hepatitis B infection.

2) Children entering the 5th grade for the first time after July 1997, must show evidence of having received 3 doses of hepatitis B vaccine. The first two doses must have been received no less than 4 weeks apart, and the interval between the second and third dose must be at least two months. Proof of prior or current infection, if verified by laboratory evidence, may be submitted for proof of vaccination (see Section 695.50(f)).

3) Only those children who have been immunized with hepatitis B vaccine in accordance with subsections (j)(1) and (2) of this Section shall be considered immune.

4) School age children entering a child care facility shall comply with the immunization requirements in accordance with this subsection (j).

(Source: Amended at 20 Ill. Reg. 11962, effective AUG 15 1996)

Section 695.30 Exceptions

a) The provisions of this Act shall not apply if:

1) The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his or her religious tenets or practices, or

2) A physician licensed to practice medicine in all its branches states in writing that the physical condition of the child is such that the administration of one or more of the required immunizing agents is medically contraindicated.

b) If a religious objection is made, a written and signed statement from the parent or legal guardian detailing such objections must be presented to the child care facility or local school authority. The religious objection statement shall be considered valid if:

1) The parent or guardian of a child entering a child care facility objects to the immunization(s) on the grounds that they conflict with the tenets and practices of a recognized church or religious organization of which the parent is an adherent or member, or

2) The objection by the parent or guardian of a child entering school (including programs under the kindergarten level) sets forth the specific religious belief which conflicts with the immunization(s). The religious objection may be personal and need not be directed by the tenets of an established religious organization.

c) ~~b)~~ It is not the intent of this Part that any child whose parents comply

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with the intent of this Act should be excluded from a child care facility or school. A child or student shall be considered to be in compliance with the law if there is evidence of the intent to comply. Such evidence may be a signed statement from the physician that he has begun, or will begin, the necessary immunization procedures, or the parent's or guardian's written consent for the child's participation in a school or other community immunization program.

(Source: Amended at 20 Ill. Reg. 11962, effective AUG 15 1996)

Section 695.50 Proof of Immunity

a) Proof of immunity shall consist of documented evidence of the child having received a vaccine (verified by a health care provider, defined as a physician, child care or school health professional, or health official) or proof of disease (as described in subsections (c) through (f) ~~e~~ below). As used in this Section, "physician" means a physician licensed to practice medicine in all of its branches (M.D. or D.O.).

b) The day and month of the vaccine is required if it cannot otherwise be determined that the vaccine was given after the minimum interval or age.

c) Proof of prior measles disease must be verified with the date of illness signed by a physician, or laboratory evidence of immunity ~~by an antibody titer of 1:16 or equivalent titer) or greater~~.

d) The only acceptable proof of immunity for rubella is evidence of vaccine (see subsection (b) above) or laboratory evidence of immunity ~~a blood titer of 1:16 (or equivalent titer) or greater~~.

e) Proof of prior mumps disease must be verified with date of illness signed by a physician or laboratory evidence of immunity. Laboratory evidence of mumps is only acceptable if the diagnostic test utilized to assess immunity is one with demonstrated reliability, including neutralization, enzyme-linked immunosorbent assay (ELISA or EIA), or radial hemolysis antibody test. A four-fold rise in mumps antibody titer between appropriately spaced acute and convalescent sera is also acceptable as proof of immunity.

f) Proof of prior or current hepatitis B infection must be verified by laboratory evidence. Laboratory evidence of prior or current hepatitis B infection is only acceptable if one of the following serologic tests indicates positivity: HBsAg, anti-HBc and/or anti-HBs.

(Source: Amended at 20 Ill. Reg. 11962, effective AUG 15 1996)

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Section 695.APPENDIX A Vaccination Schedule for Haemophilus influenzae type b Conjugate Vaccines (Hib) ~~(HbCV)~~

Vaccine	Age at 1st dose (mos.)	Primary series	Booster	Total number of doses for series
HbOC/PRP-T				
HibTITER(TM)	2-6	3 doses,2mo.apart(a)	12-15 mo.(b)(c)	4
~~Hederix-Praxis~~	7-11	2 doses,2mo.apart(a)	12-18~~15~~ mo.(b)(c)	3
~~(HbOC)~~	12-14	1 dose	15 mo.(b)(c)	2
ActHib(e)(TM)	15-59	1 dose(d)~~(e)~~	None	1
OmniHib(TM)				
TETRAMUNE(TM)				
PRP-OMP				
PedvaxHIB(TM)	2-6	2 doses,2mo.apart(a)	12 mo.(b)(c)	3
~~(Merck-Sharp~~	7-11	2 doses,2mo.apart(a)	12-18~~15~~ mo.(b)(c)	3
~~and-Dohme)~~	12-14	1 dose	15 mo.(b)(c)	2
~~(PRP-OMP)~~	15-59	1 dose(d)	None	1
PRP-D				
ProHIBIT(TM)				
~~(Connaught~~	15-59	1 dose(c)(d)	None	1
~~(PRP-D)~~				

(a) Minimally acceptable interval between doses is one month

(b) At least two months after previous dose

(c) After the primary infant Hib vaccine series is completed, any of the licensed Hib conjugate vaccines may be used as a booster dose

(d)~~(e)~~ Children 15-59 months of age should receive only a single dose of Hib ~~HbCV~~ vaccine

(e) Reconstituted with DTP as a combined DTP/Hib vaccine

(TM) Trademark

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Note: A DTP/Hib combination vaccine can be used in place of HbOC or PRP-T

(Source: Amended at 20 Ill. Reg. 11962, effective AUG 15 1996)

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: Assessment for Determining Eligibility and Renabilitation Needs

2) Code Citation: 89 Ill. Adm. Code 553

3)

Section Numbers:	Proposed Action:
553.20	Amendments
553.40	Amendments
553.50	Amendments
553.70	Amendments
553.80	Amendments
553.90	Amendments
553.100	Amendments
553.105	Amendments
553.110	Amendments
553.120	Amendments
553.140	Amendments

4) Statutory Authority: Implementing and authorized by Section 3 of the Disabled Persons Rehabilitation Act [20 ILCS 2405/3].

5) Effective Date of Amendment: August 16, 1996

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which they expire: N/A

7) Date Filed in Agency's Principal Office: August 16, 1996

8) Reason for Emergency: DORS' current case work practices do not allow accurate determinations of eligibility to be made within the federally mandated 60 day period. DORS' failure to modify its case management practices will result in continued inaccurate determinations of eligibility. Such continued action will put DORS in jeopardy of losing federal funding for the VR program which will ultimately result in the endangerment of the life, health and safety of DORS' current and future Vocational Renabilitation customers.

9) A Complete Description of the Subjects and Issues Involved: DORS is modifying its eligibility determination process so that accurate, timely determinations can be made for individuals seeking services through the Vocational Rehabilitation Program. These changes are required so that DORS can make accurate determinations within the 60 day period mandated by the Rehabilitation Act of 1973, as amended (29 U.S.C. 701-796i).

10) Are there any proposed amendments to this Part Pending? Yes

Section Numbers	Proposed Action	Illinois Register Citation

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF EMERGENCY AMENDMENTS

553.130 Amendments 20 Ill. Reg. 10305 (August 2, 1996)

11) Statement of Statewide Policy Objectives: N/A

12) Information and questions regarding these amendments shall be directed to:

Ms. Susan Warrner, Manager
Regulations and Procedures Division
Department of Rehabilitation Services
P.O. Box 19429
Springfield, IL 62794-9429
(217) 785-3896
TTY: (217) 785-9301

If because of physical disability you are unable to put comments into writing, you may make them orally to the person listed above.

The full text of the emergency amendments begins on the next page:

DEPARTMENT OF REHABILITATION SERVICES

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF REHABILITATION SERVICES
SUBCHAPTER b: VOCATIONAL REHABILITATION

PART 553
ASSESSMENT FOR DETERMINING ELIGIBILITY AND REHABILITATION NEEDS

Section
553.10 General Applicability
553.20 Basis for the Determination of Eligibility
EMERGENCY
553.30 Presumption of Benefit from Vocational Rehabilitation Services
553.35 Services to Non-United States Citizens
553.40 Eligibility Determination Time Frames
EMERGENCY
553.50 Outcome of the Eligibility Determination
EMERGENCY
553.60 Documentation of Eligibility Factors-Preliminary Assessment
553.70 Certification of Eligibility
EMERGENCY
553.80 Extended Evaluation
EMERGENCY
553.90 Outcome of Extended Evaluation
EMERGENCY
553.100 ~~Comprehensive~~ Assessment of Rehabilitation Needs
EMERGENCY
553.105 Assistance in Attaining Necessary Financial Support
EMERGENCY
553.110 Outcome of the ~~Comprehensive~~ Assessment of Rehabilitation Needs
EMERGENCY
553.120 Change in Eligibility Status
EMERGENCY
553.130 Order of Selection
553.140 Criteria for Severe Disability and Most Severe Disability
EMERGENCY
553.150 Determination of Serious Limitation to Functional Capacities

AUTHORITY: Implementing and authorized by Section 3 of the Disabled Persons Rehabilitation Act [20 ILCS 2405/3].

SOURCE: Emergency rules adopted at 17 Ill. Reg. 11657, effective July 1, 1993, for a maximum of 150 days; adopted at 17 Ill. Reg. 21346, effective November 15, 1993; amended at 19 Ill. Reg. 1834, effective February 6, 1995; amended at 19 Ill. Reg. 10149, effective June 29, 1995; amended at 19 Ill. Reg. 15730, effective November 7, 1995; emergency amendment at 20 Ill. Reg. 10385, effective July 18, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days.

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Section 553.20 Basis for the Determination of Eligibility
EMERGENCY

An individual shall be determined to be eligible to receive services through the VR Program if he/she:

a) is an individual with a disability as defined in Section 7(8)(A) of the Rehabilitation Act of 1973 (29 USCA 701 et seq.), as amended (Act). Pursuant to the Act, to be an individual with a disability, an individual must have a physical or mental impairment which results in a substantial impediment to employment, and who can benefit from vocational rehabilitation services in terms of an employment outcome; and

b) requires VR services to prepare for, enter, engage in, or retain gainful employment; and ~~.~~

c) meets the priority for services established under DORS' Order of Selection in Section 553.30.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.40 Eligibility Determination Time Frames
EMERGENCY

After receiving a completed application for VR services, DORS shall make an eligibility determination and determine the individual's priority to receive services under the Order of Selection within a reasonable time period, not to exceed 60 calendar days from the date the individual applies for services unless:

a) DORS notifies the individual that exceptional and unforeseen circumstances beyond DORS control preclude DORS from completing a timely determination and the individual agrees to an extension; or

b) DORS determines, on the basis of the criteria set forth at 89 Ill. Adm. Code 553.30, that a period of extended evaluation is necessary to document whether or not the individual can be expected to benefit from VR services in terms of an employment outcome or to identify employability for the customer.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.50 Outcome of the Eligibility Determination
EMERGENCY

Prior to the end of the eligibility determination period (i.e., 60 days), one of the following must occur:

a) the customer has been ~~client is~~ determined to be eligible to receive VR services and has a disability which will allow services to be

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provided under the Order of Selection. The customer will then undergo an Assessment of Rehabilitation Needs pursuant to Section 553.100 of this Part ~~based on the criteria set forth in Section 553.20. A Certification of Eligibility shall be completed and the individual shall be placed on a waiting list to wait until services can be provided to the priority category established under the Order of Selection or to have his/her case closed;~~

b) the customer is determined eligible but not to have a disability which allows services to be provided under the Order of Selection. The customer will be offered the option to have his/her name placed on a waiting list to wait until services can be provided to the priority category established under the Order of Selection or to have his/her case closed;

c) ~~b)~~ an extended evaluation is determined necessary. A Certification of Extended Evaluation shall be completed and such an evaluation shall begin;

d) ~~c)~~ the customer ~~client~~, because of lack of a disability ~~which for that individual constitutes or results in an a substantial impediment to employment~~, is determined to be ineligible to receive services. A Certification of Ineligibility shall be completed and the individual's case closed;

e) ~~d)~~ the customer's ~~client's~~ case is closed for reasons other than ineligibility (e.g., the customer ~~client~~ has refused services or further services from DORS, the customer ~~client~~ cannot be located); or

f) ~~e)~~ the customer's ~~client's~~ case is closed as he/she is determined ineligible to receive services due to the fact he/she does not meet the required criteria (see 89 Ill. Adm. Code 553.20).

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.70 Certification of Eligibility
EMERGENCY

At any time during the eligibility determination process, but no later than 60 days from the date of an individual's application for services except as provided in Section 553.40 of this Part, a Certification of Eligibility, per 89 Ill. Adm. Code 553.40, shall be completed unless extenuating circumstances exist and is agreed upon by the individual or a period of Extended Evaluation (89 Ill. Adm. Code 553.80) is determined to be necessary.
The Certification of Eligibility shall document the basis on which the customer ~~client~~ was determined to be eligible, including identification of the individual's disability, description of the individual's need for ~~describe specifically why the individual is in need of~~ VR services to reach an employment outcome, indication of the priority category to which the individual has been assigned under the Order of Selection and an outline of the services that are expected to be necessary to determine the individual's service needs during the Comprehensive Assessment of Rehabilitation Needs (89 Ill. Adm. Code

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553.100).

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.80 Extended Evaluation
EMERGENCY

a) If, prior to the expiration of the 60 calendar day eligibility determination period, it is determined that sufficient evidence exists to justify the need for extended evaluation, a Certification of Extended Evaluation shall be completed and such an evaluation shall commence. The Certification of Extended Evaluation shall identify why a determination of eligibility could not be completed during the 60 calendar day eligibility determination period and specifically outline the services that are to be provided during extended evaluation to determine the individual's eligibility or ineligibility.

b) The ~~sole~~ purpose of the extended evaluation shall be to determine whether or not the individual can benefit from services in terms of a successful employment outcome and/or to identify employability. DORS may not deny the individual access to VR services, unless DORS can prove through clear and convincing evidence that the individual is incapable of benefiting from VR services in terms of a successful employment outcome.

c) The period of extended evaluation shall not exceed 18 months calculated from the date of the Certification of Extended Evaluation and shall be reviewed every 90 days.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.90 Outcome of Extended Evaluation
EMERGENCY

a) If, after a period of Extended Evaluation, the customer ~~client~~ is determined eligible, a Certification of Eligibility shall be prepared and the customer ~~client~~ shall begin an ~~a~~Comprehensive Assessment of Rehabilitation Needs (see 89 Ill. Adm. Code 553.100).

b) If DORS, after a period of extended evaluation, is unable to demonstrate through clear and convincing evidence that the individual cannot benefit from VR services in terms of an employment outcome, he/she shall be presumed to be able to benefit from services (89 Ill. Adm. Code 553.30) and shall be certified as eligible to receive VR services.

c) When clear and convincing evidence is in the case file documenting the individual is not capable of ~~benefiting~~ ~~benefitting~~ from VR services, certification of Ineligibility shall be completed, which includes a summary and rationale for the determination based on the information

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gathered during the period of extended evaluation.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.100 ~~C~~omprehensive Assessment of Rehabilitation Needs
EMERGENCY

a) If a customer ~~client~~ is determined eligible to receive VR services (89 Ill. Adm. Code 553.50(a)), ~~the he/she must undergo a Comprehensive~~ Assessment of Rehabilitation Needs (Comprehensive Assessment) shall be completed.

b) A major component of the ~~C~~omprehensive Assessment shall be the determination of the employment goal. The goal shall involve the customer ~~client~~ and take his/her interests into consideration, as well as career counseling provided to and with the customer ~~client~~ by the counselor regarding labor market trends and training requirements. The employment goal chosen by the customer ~~client~~ should be supported by the counselor unless the ~~C~~omprehensive Assessment clearly contraindicates the customer's ~~client's~~ choice.

c) The ~~C~~omprehensive Assessment will include a review of existing and additional information as to the individual's career plan, unique strengths, resources, priorities, interests, and needs to determine the nature and scope of services necessary to ensure the individual a successful employment outcome in the area of his/her chosen goal.

d) The scope of the ~~C~~omprehensive Assessment shall be limited to that which is necessary to identify the rehabilitation needs of the individual and to develop the Individualized Written Rehabilitation Program (IWRP) (89 Ill. Adm. Code 572) for the individual. To the maximum extent possible the information used shall be existing information and information available from the individual and, where appropriate, from the individual's family.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.105 Assistance in Attaining Necessary Financial Support
EMERGENCY

At the conclusion of the ~~C~~omprehensive Assessment ~~of Rehabilitation Needs~~, after the determination of a suitable vocational goal, if the customer ~~client~~ cannot be expected to be able to attain a successful employment outcome due to lack of financial resources and there are benefits for which the customer ~~client~~ can be expected to be eligible, the rehabilitation counselor/instructor must assist the customer ~~client~~ in making application for such benefits.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.110 Outcome of the ~~Comprehensive~~ Assessment of Rehabilitation Needs
EMERGENCY

a) When it is determined by the counselor that enough information has been gathered during the ~~Comprehensive~~ Assessment to adequately determine and plan the VR services necessary to ensure the individual a successful employment outcome in the area of his/her chosen employment goal, an ~~a--Comprehensive~~ Assessment Summary shall be completed by the counselor as part of the chronological record. The ~~Comprehensive~~ Assessment Summary shall identify, in detail, the specific impairments the individual has in obtaining his/her vocational goal, documentation of career counseling, consideration of the individual's unique strengths, resources, priorities, and interests needed to identify the nature and scope of services and the specific services that are expected to be necessary to assist the customer ~~client~~ in achieving his/her employment outcome.

b) The ~~Comprehensive~~ Assessment Summary must also include a statement addressing the severity of the individual's disability(ies) and addressing the individual's eligibility based on the Order of Selection (pursuant to Section 553.140).

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.120 Change in Eligibility Status
EMERGENCY

If, at any time during the eligibility process or ~~Comprehensive~~ Assessment, the customer's ~~client's~~ condition changes to the extent he/she is no longer considered to have a disability, all case activity services shall cease, a Certificate of Ineligibility shall be completed and the customer's ~~client's~~ VR case closed. Customers ~~Clients~~ have the right to request a review of this determination under the procedures of 89 Ill. Adm. Code 510-Appeals and Hearings.

(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

Section 553.140 Criteria for Severe Disability and Most Severe Disability
EMERGENCY

a) Criteria for determining that the individual has a severe disability or a most severe disability must be in the individual's VR case file, stated and justified in the Assessment Summary (89 Ill. Adm. Code 553.70 and 89 Ill. Adm. Code 553.110) based on the following information.

b) To be considered an individual with a most severe disability in determining priority for services under the Order of Selection (Section 553.130 of this Part), the individual must meet all of the criteria listed in subsection (c), below, with the exception that the customer's disability must seriously limit three or more of the functional capacities, as listed in Section 553.150 of this Part.

c) To be considered an individual with a severe disability, he/she must have a disability which is determined by the rehabilitation counselor instructor to meet all four of the following criteria:

1) The severe disability seriously limits at least two ~~one--or--more~~ of the individual's functional capacities, as listed in Section 553.150 of this Part.

2) The individual has a disability or combination of disabilities determined by an evaluation of rehabilitation potential to cause a substantial physical or mental impairment similar but not limited to the following list of disabilities:
   A) amputation,
   B) arthritis,
   C) autism,
   D) blindness,
   E) burn injury,
   F) cancer,
   G) cerebral palsy,
   H) cystic fibrosis,
   I) deafness,
   J) head injury,
   K) heart disease,
   L) hemiplegia,
   M) hemophilia,
   N) respiratory or pulmonary dysfunction,
   O) mental retardation,
   P) mental illness,
   Q) multiple sclerosis,
   R) muscular dystrophy,
   S) musculo-skeletal disorders,
   T) neurological disorders (including stroke and epilepsy,
   U) paraplegia,
   V) quadriplegia (and other spinal cord conditions),
   W) sickle cell anemia,
   X) specific learning disabilities, or
   Y) end stage renal failure disease.

3) Three or more VR services, which may include counseling and guidance services provided by the rehabilitation counselor/instructor, will be required to ensure the individual a successful employment outcome.

4) VR services will be required over an extended period of time. An extended period of time for the purposes of the VR Program is defined as 6 months or more.

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(Source: Emergency amendment at 20 Ill. Reg. 11974, effective August 16, 1996, for a maximum of 150 days)

OFFICE OF BANKS AND REAL ESTATE

NOTICE OF CODIFICATION CHANGE

1) Heading of Title: Professions and Occupations

2) Code Citation: Title 68

3) Date of Index Department Review: August 16, 1996

4) Headings of Parts Affected:

Administrative responsibility for the Real Estate License Act of 1983 and the Land Sales Registration Act of 1989 was transferred in July, 1995 from the Department of Professional Regulation to the Office of the Commissioner of Savings and Residential Finance by Public Act 89-23. The Department's rules previously adopted under those two laws were transferred to the Commissioner's Office.

The Office of the Commissioner of Savings and Residential Finance and the Commissioner of Banks and Trust Companies were merged on June 1, 1996 to form the Office of Banks and Real Estate by Executive Order #1 (1996). That merger was codified by Public Act 89-508. As part of the merger, the rules of the two predecessor agencies, including the three Parts listed below, were made the rules of the new agency.

In this codification change, Part and section numbers are not changing. Only changes relating to Chapter headings, some Subchapter headings, some Part headings, references to the agency, and other non-substantive technical changes reflecting the transfer of real estate regulation and the merger of the two agencies are being made at this time.

Part Numbers:	Headings:
1260	Land Sales Registration Act of 1989
1450	Real Estate License Act of 1983
1455	Real Estate Appraiser Certification

Rules acted upon during the quarter of July 1 thorugh September 30, 1996 are listed in the Issues Index by Title number, Part number and Issue number. For example, 50 Ill. Adm. Code 952 published in Issue 2 will be listed as 50-952-2. Inquiries about the Issues Index may be directed to the Administrative Code Division at 217-782-4414 or jnatale@ccgate.sos.state.il.us (Internet address).

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